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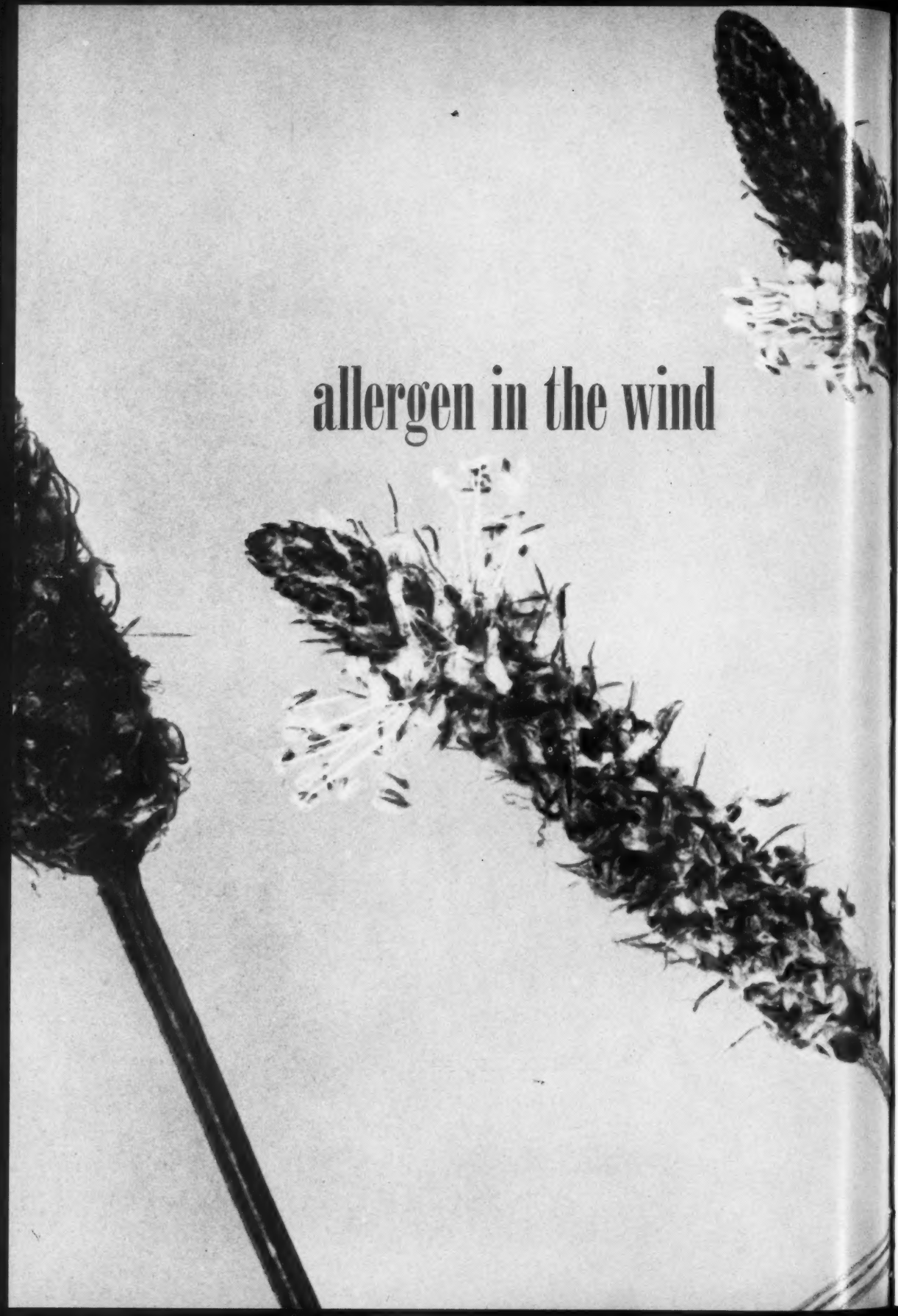
allergen in the wind

Editorial

Making Sense*

"The meaning of words has a profound effect on the progress of medicine; for words, though they provide a vehicle by which thought can travel, seldom allow it to arrive intact at its destination.

Facts and Words

"It is pleasant to believe that the facts of clinical medicine exist quite independently of the names we bestow upon them; but this is not so. In clinical medicine it is not only a matter of finding words to fit the facts, but often finding facts to fit the words. When christening a baby we wait for the child to be born and then find a name for it. When christening a disease we wait for the name to be born and then we try to find a disease for it.

" . . . . A good example of creation beginning with the word is gallstone colic. There is no such thing.[1] Colic is a pain continuously waxing and waning, like the colonic cramps of food-poisoning. Gallstone pain steadily climbs to an agonising peak without any fluctuation and then passes off. But so firmly has the label colic been stuck on to this pain that the pain is expected to be colic, assumed to be colic, believed to be colic and finally bullied into being colic, and a patient with gallstone pain will be described as having colicky pain however steady it may be.

"Contrariwise, a condition without a descriptive term has far less chance of clinical recognition. A rose without a name may smell as sweet, but it has far less chance of being smelt. Supposing we take an unnamed fever and an unnamed pain to contrast with the examples I have given. In untreated pernicious anaemia there is often quite a high fever. 60% of my cases with red-cell counts below 1½ million per c.mm. show a fever over 101°F. This usually settles to normal levels within two or three days after an adequate dose of vitamin B_{12}. I make no claim that this fever is of great importance, but I do assert that had it been called the Addison-Castle fever or hypocyanocobalaminic fever every medical student in the land would have heard of it, many doctors would be afraid to diagnose pernicious anaemia without its presence, and the proportion of patients with this fever would rise sharply once the name got into nurses' textbooks (because if they did not show the fever they would have their thermometers put back in their mouths until they did).

" . . . . A special kind of disease-naming is done by those branches of industry whose sales depend largely on the planned creation of non-existent diseases, such as night starvation, hidden hunger, and tired blood. In this highly creative and imaginative work the importance of a good name cannot be exaggerated. One weekly paper ran a competition for an advertisement introducing a new disease with a patent medicine to cure it. Here are a few extracts from one of the winning entries:

> " 'Have you shoddy juvicles? Do you moil at night and wake prinkling, with a throbble? You are almost certainly suffering from Gloids. Waste no time. Write immediately in strict confidence for our free booklet prepared by a well-known Harley Street doctor. Mark envelope Dr. X. Gloids. Dept. KZ. All enquiries treated with strictest confidence.'

Although this may treat patent-medicine disease as a joke, it is a serious matter. We do not know how many bowel neuroses are initiated by relentlessly persuading the public into vain strivings after inner cleanliness.

*From the second Lettsomian Lecture by Richard Asher, M.D., F. R. C. P., delivered before the Medical Society of London on Feb. 9, 1959. Abstracted by permission from **The Lancet** 2: 359 (Sept. 19) 1959. See the **JOSMA**, July, 1960 for abstracts of the first lecture.

1. French, E. B. Unpublished paper read to the Association of Physicians, Edinburgh, 1957.

" . . . . There are many syndromes that have no name. For instance, there is no name for an unexplained bout of fever and malaise lasting two or three days and commoner in children than in adults. The layman calls this 'flu'; but the doctor, who correctly prefers to reserve this term for the pandemic condition caused by an identifiable virus, is powerless when faced with this condition. P.U.O. is properly reserved for more lengthy fevers. In hospital, the consultant occasionally takes refuge by filling in the diagnosis as flu and then putting inverted commas round it to show he is unhappy. In his own home, when one of his family gets it, he is worse off. He mutters vaguely:

" 'Take an aspirin or two and it'll clear up in a few days. It's nothing much. Just one of those things.'

If this does not satisfy his wife, he may be driven by sheer nomenclatural bankruptcy to call in a colleague to show his wife that another doctor cannot do any better.

"Thus words perpetuate illnesses, syndromes and signs whose existence is doubtful, deny recognition to others whose existence is beyond question and distort textbook descriptions to conform to the chosen word. It is worth pursuing the subject a little further.

Power of Words

"An ancient and important property of names is that they give to those who know them a feeling of power over what is named. However uninformative the name of his illness may be a patient feels his foe is partially vanquished once he knows its name. We all know the conversation:

" 'I seem to have an inflamed tongue, doctor. Will you have a look at it?'

" 'Ah, yes. You've got glossitis.'

" 'Thank you, doctor. It's all right now I know what it is.'

"Ogden and Richards[2] point out that every country has its story of a name that has to be discovered before an evil can be dispelled or a foe vanquished. Probably the best known of these is the story of a dwarf called Rumpelstiltskin who was able to claim a queen's first-born child unless she could find his name. With such an unusual name, he was understandably (but mistakenly) confident of success. It is not a name a nicely brought-up girl would be likely to know, for it means 'crinkly foreskin.'

"Similar stories abound in international folklore depending on the idea, that knowing the name of a thing gives power to him who knows it.

" 'What is this strange skin condition with red rings which expand from the centre in widening circles?'

" 'That', says the dermatologist, 'is erythema annulare centrifugum.'

"He has spoken the words of power, and the dignity of the profession has been upheld.

"Other words appear to hold power against the patient. If you tell a woman she has rheumatism, she asks, fearfully and tentatively:

" 'But is it arthritis, doctor?'

"The significance of words to our patients is a subject on which systematic research could gainfully be pursued. Arthritis appears to portend a protracted and crippling disease which will leave a man deformed and helpless, whereas rheumatism betokens a few aspirins, a bottle of liniment, and back to work next week. But names give comfort as often as despair, providing an illusion of clarity where there was mystery and giving a tangibility to illness which makes it more likely to be overcome. This applies both to patients and to doctors. The penetrating mind of Matthew Arnold saw through the emptiness of a name and in his poem *A Wish* he wrote:—

> Nor bring to watch me cease to live
> Some Doctor, full of phrase and fame
> To shake his sapient head and give
> The ill he cannot cure—a name.

"I may seem to imply that words only provide comforting illusions, or suitably opaque coverings for ignorance. That is not my intention; but I believe it essential to be aware of the defects and limitations of the medical vocabulary before it can be successfully used.

The Meaning

"The study of meaning is a subject so surrounded with difficulties and contradic-

2. Ogden, C. K., Richards, I. A. The Meaning of Meaning: p. 26. London, 1923.

tions that few people dare speak about it confidently. The only exception was Humpty Dumpty, whose views were admirably clear and confident:

> " 'When I use a word', Humpty Dumpty said in a scornful tone, 'it means what I choose it to mean, neither more or less.'
>
> " 'The question is', said Alice, 'if you can make a word do that.'
>
> " 'The question is', said Humpty Dumpty, 'which is to be master, that's all.'

This Humpty Dumptyrian attitude is not enough for medical semantics. When we use a word it has to mean the same to us as it does to the person we are addressing or else our thoughts are not transmitted intact. Consider the meaning of meaning as it applies to some words in the medical vocabulary.

> "First, there is the *etymological* meaning. For example, take the word 'meconium', which means poppy.
>
> "Secondly, there is the *implicational* meaning, the notions either true or false upon which the etymological meaning is based. In this case that meconium causes drowsiness as poppy seeds do, and also that the foetus in utero is kept asleep thereby.
>
> "Thirdly, there is the *referential* meaning. In this case, the black stuff in a baby's colon.

I choose this word because there is little doubt about its meaning today. But this is a matter of luck. Had it followed its original derivation it might have come to mean 'the opiates present in the foetal stools'. Then the word would have died as soon as there was general agreement that the foetal stools contain no opiates. Had the word taken another turn it would have meant 'that substance which keeps a foetus asleep in utero'; various theories as to its composition might have arisen and discussions taken place on whether a foetus sleeps in utero.

" . . . . If I labour the point I apologise, but I am convinced it is of great importance. To name a thing by its supposed cause, whether or not that cause is the right one, is a very serious mistake. To label by conjecture, instead of by observed facts is neither necessary or profitable. I am quite happy with the word myxoedema (which means 'a jelly-like swelling') and do not wish to call it hypothyroidism even though I believe that hypothyroidism is almost certainly its cause.

"The ramifications of casual names are unending. As the *Book of Job* has it:

> " 'Who is this that darkeneth counsel by words without knowledge?'

When I was a student, blood beneath the dura mater was not called subdural haematoma but pachymeningitis interna haemorrhagica. This convinced everyone that it was caused by inflammation and held up the discovery that head injuries caused subdural bleeding which can be surgically treated. Take another example. We all see middle-aged women with restless, painful, arms, worse at night and worse after doing the washing. It is a common condition and nobody really knows what causes it. Yet according to the wide varieties of cause which are suspected—so is it given as many names. Brachial neuritis, the costoclavicular syndrome, the scalenus-anticus syndrome, cervical rib, the carpal-tunnel syndrome. This is impossibly silly. If this condition had some reasonable name like 'nocturnal brachialgia' then we could profitably discuss whether it was caused by a neuritis or by costoclavicular compression or by compression of the median nerve in the carpal tunnel. But to name it the costoclavicular syndrome and then to discuss whether the costoclavicular syndrome is caused by carpal-tunnel compression makes no sense, anatomically or physically. However sure of a cause clinicians may be, a diagnostic label must be descriptive and not casual.

Targets, Navels, Mexican Hats, and Bowls

"Other types of conjectural naming are equally troublesome.

"In haematology cells are often named by what is guessed about them instead of what they look like. (I apologise for the words 'what they look like.' No proper pathologist ever reports what anything looks like—he only reports what it 'is morphologically indistinguishable from.') Though we know a lot of what red cells do, we still call them red cells—an admirable term. Other cells are less fortunate, for instance those red cells which may be found in obstructive jaundice, sickle-celled anaemia, and other

conditions. Instead of a pale centre these have deeply stained centres and thus show alternate dark and light concentric zones. About 1936, A. M. Barrett, who was a fellow student with me, became interested in them. He sensibly called them 'target cells[2]' which describes them well, and involves no conjecture about why they look like this or what properties they have. Someone else thought they looked like navels and called the abnormality 'umbonation' which, though more fanciful, is at least not conjectural. But soon afterwards two Americans[3] noticed these cells and likened them to Mexican hats: not from their appearance in stained films, but from their ideas of what they would look like if they could be seen alive. 'They do not look like Mexican hats', they implied, 'but we are sure they would, if we could see them as they really are.'

"The modern view is that these cells are abnormally thin and bowl-shaped; hence their ability to hold more fluid without bursting than any other red cells can do. So today, when a haematologist sees a cell which looks like a target he calls it a thin cell—i.e., leptocyte—though he cannot perceive that it is thin. Barrett sensibly named them by their appearance, even though he thought they were thin. The modern haematologist, instead of describing in English what he can see, prefers to describe in Greek what he can't. This is confusing because the appearance of target cells is observed but their thinness and shape is estimated. Appearances do not change as much as estimations. The Mexican-hat merchants estimated that the target cells were of normal thickness, but unduly fragile to weak saline, which is the opposite of the modern view. Had they named target cells by these estimated properties we should be in a worse muddle. In naming anything, some unchangeable attribute of that thing should be chosen to name it by.

"The other day I saw a report mentioning leptocytes, which was just going to a general practitioner. I tried to imagine how the perfect practitioner was expected to reason:

> " 'Ah yes, "leptocytosis"—thin cells. He guesses they were thin, because he believes they would hold a lot of water—because he thinks they would be shaped like bowls (or Mexican hats)—if he was only able to see what their shape was (which he can't). In other words he saw a red dot in the centre of some of the cells. Yes, that's all perfectly clear.'

"Haematologists cannot be prevented from thinking, but they could separate their observations from their conjectures. They could report 'target cells present', and then go on to say what the significance of this might be. The role of a pathologist is not to be a seer. His role is to peer. Gazing into a microscope is different from gazing into a crystal. Yet haematological prophesy is rampant, particularly in obscure leukaemias. Controversy on whether cells are myeloblasts, lymphoblasts, or monoblasts is unavoidable, because instead of naming them by their appearance the haematologist inspects the artificially dyed, corpses of grossly abnormal, newborn recently deceased white cells, smeared on a piece of glass, and then prophesies what they might become if they were to grow up (which they can't). No wonder then that when some unidentified blood-cell is found wandering at large, unable to produce positive evidence of its identity, the naming of it provides a good deal of dispute and controversy among haematologists. In the first article I ever wrote, some fifteen years ago, I said:

> " 'Let us imagine a child found wandering in the street is adopted by three priests who each christen him separately by the names of Tom, Dick and Harry. One day they meet another three priests who have behaved in a similar fashion with another child whom they have christened Harry, Dick and Tom. Now if those six priests try and have a discussion on the qualities of the two children—whether, for instance, Tom is cleverer than Harry—they are likely to become angry and to settle nothing; and they will probably go home and introduce new words such as protomocyte, pseudodickoblast and megaharryophil.'[4]

"I do not wish to be carried away from the main course of my argument by floating too far down the blood-stream, so may I remind you that we are considering the meaning of meaning and that haematological words provide food for thought on the variety of meanings—etymological, descriptive, and conjectural—which may be at-

3. Haden, R. L., Evans, F. D. Arch. intern. Med. 1957, 60, 133.

4. Lancet, 1943, i, 213.

tached to them. To appreciate it properly the meaning of the word 'leptocyte' requires a considerable knowledge of Greek, toxophilism, omphalology, hydrostatics, and hat design.

The *name* of this cell is target cell, the name is *called* leptocyte. The cell *is* a bowl-shaped cell. Does that remind you of something you read many years ago?

"*White Knight*: Let me sing you a song to comfort you. . .The name of the song is called 'Haddocks Eyes'.

"*Alice*: Oh, that's the name of the song, is it?

"*White Knight*: No, you don't understand. That's what the name is *called*. The name really *is* 'The Aged Aged Man'.

"*Alice*: Then I ought to have said 'That's what the *song* is called'?

"*White Knight*: No, you oughtn't: that's quite another thing! The *song* is called 'Ways and Means'; but that's only what it's *called* you know.

"*Alice*: Well, what *is* the song then?

"*White Knight*: I was coming to that. The song really is called 'A-sitting on a Gate': and the tune's my own invention.

"Similarly, we could say: 'The *name* of this disease is Graves' disease; the name is sometimes *called* exophthalmic goitre; the *disease* is called hyperthyroidism; and the disease *is* thyrotoxicocis. Four names for the same condition. This is difficult for students and spoils words we need for another purpose. We need the term exophthalmic goitre to describe the not uncommon association of staring eyes, with goitre but without any thyrotoxicity. (By the way, notice I said 'staring'—a very useful word which covers the lid-retraction, the exophthalmos, and the increased glitter from the moist eyeball, which together comprise staring. Most of you probably write exophthalmos when you mean staring. The idea that a long word is more accurate seems to be inborn. For example I am sure you rarely use that accurate and short word 'stroke'. No, you write down cerebral thrombosis, cerebral haemorrhage, or cerebral embolus, according to your fancy, though you have little idea how to tell one from the other; even at postmortem pathologists may be uncertain. Though there is this short word which covers all three, you choose a long word which describes a guess. It is odd. I suppose it is the dislike of sharing words with the laity.)

Style

" . . . . Lastly, I say something about style. I don't care a fig about schoolroom stuff on the difference between phrases and clauses or the distinction between metaphors, similes, and hyperboles. But I do feel strongly about style. It is only a matter of putting down what you have to say in the neatest and most palatable form. And it cannot be done except by taking a lot of trouble in doing it.

"Recently a doctor wrote an article about bedwetting in which he wished to draw a distinction between better-educated people who plan a small but successful family and those with lower standards who raise large mediocre families. This is the way he described them (but I have condensed it a good deal).

" 'The mobile families described as showing a loose-knit kinship network and shared conjugal roles accept occupational emancipation and its consequences on interpersonal relationships. They determine the number of their children by a critical assessment of their own emotional, social and economic potential, and they strive to create one or two competitively successful children rather than a gregarious egalitarian sibling group.'

"Well I ask you? When you take your family on holiday, do you say 'I am taking my gregarious egalitarian sibling group with me'?

" . . . Yet, very often, technical words are used which add very little information, and befog the puzzled minds of those who read them. There is much talk today of the degrading effect of reading comics instead of more serious journals. Here are two descriptions of psychopathic personality—one from a serious medical journal and the other from a particularly low comic—that I borrowed from one of my children.

" 'In defining the psychological use of the term psychopathic personality I assume a pathophysiology of the brain on a multifactorial basis, genetically predisposed in which contemporary systems are malintegrated the one with the other but whose tie with what happened in infancy is historical rather than causative.

This agenesia is homologous in its physiological aspects with normal behavior.'

That one perhaps some of you guessed, is the extract from the serious journal. Now I read you extracts from a journal (which I am afraid you cannot get at the Royal Society of Medicine) ; but the reference is *Top Spot,* Oct. 25, 1958, p. 1. (All the words are in block letters in circumscribed areas within the illustrations which are lavish and colourful.

" 'This is the story of Charlie "Hot Fingers" Hart, who liked his guitar, easy lolly, flash suits and smart dames. Charlie chorded his guitar and sang in his gravel voice; his sulky lips pouted, his eyes lidded and his hips snaked.'

I wonder which of these two accounts of a psychopath you prefer? Do you altogether blame me that for the rest of the evening, instead of improving my mind by continuing to read that most respectable medical journal, I sat wrapped in the story of Charlie 'Hot Fingers' Hart?"

"On Call to a Nation"

The above title is applied to the sound-moving picture report of the first 10 years of "Socialized Medicine" in England. The wording is especially significant in view of the comment of one of the narrators who said the physicians were *legally bound to be on call 24 hours every day.* Any time a physician desires to take off he must arrange for another to answer his calls.

Though unfamiliar with the trades in England we think one would be safe in assuming the Government does not so rigidly control the hours of service nor the availability of *ANY* other group of people as it does the Medical Profession under its present system of Medical Care which went into effect July 5, 1948. There was some difficulty in understanding the English physicians and narrators but in general the method of handling patients was evident. Lined up on long benches and occasionally on chairs in the waiting rooms, the patient at the head of the group would move out as his name was called and all in the waiting room would move up one position. New arrivals went automatically to the rear of the line. Physical examinations were apparently not often done, interviews were brief, prescriptions were handed out, and the patients referred for consultation or hospitalization. Ancillary help or office assistants were not available for many of the private practitioners—usually only the association of three or more physicians in groups enabled them to have the service of a secretary or a nurse.

Referral of a patient for hospitalization, special study, consultation or for operation by no means assured him of these services within any reasonable period of time.

Physicians' responses to questioning as to how they liked the plan, and how it affected the welfare of the patients were extremely interesting because almost without exception those physicians who had been in practice prior to the inception of Socialized Medicine, July 1948, said they could not do for their patients as much as they formerly were able to do, either in actual treatment of the patient or in referring him for consultation or for necessary operations. Those younger men who had been in practice only under the system remarked that they thought the plan was good, but NEVER did there appear much enthusiasm on their part. Among some of the startling statements which were made in this report which stand out as danger signals to everyone in this country are these:

(1) 500,000 patients already approved and certified for hospitalization are awaiting admission.

(2) It is necessary to go back to 1870 to find a decade in which fewer additional hospital beds were made available in England than in the first ten years of Socialized Medicine. This is particularly significant because more beds, hospitals, and better hospital services were promised by the advocates of the plan as the natural and expected benefits to the people.

(3) More than 50% of ALL hospital

beds in England are occupied by the chronically ill, the aged and the mentally sick thereby greatly limiting the number of beds for acute illnesses and for surgical treatment.

(4) One hospital administrator speaking of his own hospital, stated that the waiting list on General Surgery was more than 800 and some had been on the list for three years. In the same institution Orthopedic Surgery had in excess of 600 cases waiting for hospital admission, and some of these had been on the list for six years, and so on through other services.

(5) A warehouse erected in 1918, comparable to the more recent quonset hut is now in use as an Ear, Nose and Throat division of one of the larger hospitals.

In contrast to the hospital bed situation in England under 10 years of Socialized Medicine, 1948-1958, we in this country in almost exactly the same period of time, 1948-1959, increased the number of hospital beds 30% or an increase of 305,000 beds.

It is tragic that the entire picture of Socialized Medicine with its weaknesses and pathetic inadequacies cannot be so graphically presented to the American public, legislators, writers and newspaper people that we all might be made acutely conscious of the great hazard we face in losing the most advanced medical knowledge and most *nearly adequate* medical care the world has ever known.

The report does not discuss the cost of services rendered, nor does it mention the cutbacks, limitation or fees imposed.

In 1948, the British Government estimated the cost of the National Health Service for *free* medical and health care for *everyone* would be 170 million pounds (about $476,000,000) annually.

An AMA pamphlet entitled "The Pill That Could Change America" gives the following information—

"First full year National Health Service was in operation it cost 440 million pounds —nearly triple the estimate. In 1958, the NHS bill has soared to 705 million pounds annually. British Chancellor of Exchequer told the House of Commons in 1958, "free health service whatever it may be doing for the health of Britons, is leaving the Treasury gasping. In 1959, the service will cost 740 million pounds (2 billion dollars)."

AMA News, Sept. 1959 says:

"The British Labor Party, in a 6,000-word policy statement proposing a broad shake-up in Britain's National Health Service, said it found 500,000 people waiting for hospital beds, doctors underpaid, with more money being spent on the drugs they prescribe than on the MDs themselves, and 'millions of hours' being wasted by people in waiting rooms."

The film may be obtained through the Film Library of the American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.—*George H. Garrison, M.D.*

Scientific Articles

Mucormycosis

A case report and a brief review of the literature on this little known disease entity.

RICHARD A. BAYLOR, M.D.

HENRY J. BIERMANN, M.D.

Richard A. Baylor, M.D., graduated from the State University of Iowa College of Medicine in 1929. He is now staff physician at the Veterans Administration Hospital in Oklahoma City.

Henry J. Biermann, M.D., graduated from the Creighton University School of Medicine in 1952 and limits his practice to General Surgery. He is staff surgeon at the Veterans Administration Hospital at Muskogee, Oklahoma.

MUCORMYCOSIS is not a new disease, but it is still relatively rare. There have been 13 cases reported in the United States between 1943 and 1956. The disease entity was first described by Paltauf in 1885. These fungi are not usually considered pathogens. They are probably world-wide in distribution and are frequent laboratory contaminants. In human infections they tend to become active in patients with diabetes mellitus, leukemia, multiple myeloma and cirrhosis of the liver. Predisposing factor is usually heavy doses of antibiotics, steroid compounds or antileukemic drugs.[1,2,3]

Pathology

This fungus has a marked predilection for blood vessels. It penetrates the muscular layer of the arteries and then grows within the lumen tending to occlude the lumen and, therefore, to form infarcts. It may also affect the veins and lymphatics. In the veins it can form thrombi. Common sites of infection are paraorbital tissues, paranasal sinuses, lung, brain and gastrointestinal tract. A disseminated form has also been reported. Contrary to most fungus diseases, mucormycosis tends to run an acute course. Recovery of patients with sinusitis and orbital cellulitis has been reported. Diagnosis is made by demonstration of the organism in the tissue, smear or culture. There is no specific therapy. Treatment is of the underlying disease. Desensitization of the patient to an autogenous vaccine has been used. Iodides have been of some benefit.

Case Report

This 39 year old colored veteran was admitted to the Veterans Administration Hospital, Muskogee, Oklahoma on November 25, 1959 because of cellulitis of the left hand for three days. A diagnosis of diabetes mellitus had been established in January, 1948. Before entering the hospital the patient had been taking 36 units of NPH insulin daily. He had numerous previous admissions to this hospital due to problems in diabetic control.

On physical examination the patient was a tall, lanky colored male 39 years of age.

There were numerous large tender indurated lymph nodes in the left axilla. In the left epitrochlear area there were two or three large tender nodes. The entire left hand was edematous and swollen to once again its normal size. There was an ulcer of the skin 1 cm. in diameter on the dorsum of the fifth metacarpophalangeal joint. Bloody pus exuded from this when pressure was applied to the dorsum of the hand over the fourth and fifth metacarpals. The superficial epithelium was desquamated over the distribution of the ulnar nerve on the dorsum of the left hand. He had difficulty in flexing the fourth and fifth fingers. When this was done forcibly there was pain in the carpal tunnel. There was, however, no swelling in the carpal tunnel and no area of fluctuance in the hypothenar or mid-palmar spaces. There were no red streaks up the arm. The remainder of the physical examination was essentially negative except for evidence of diabetic neuropathy on neurological examination. Working diagnoses were: (1) cellulitis with abscess formation, left hand; (2) diabetes mellitus, severe; and (3) diabetic neuropathy, both lower legs.

Of note in the urinalysis on admission was albumin 4 plus, sugar 4 plus, negative acetone and a few erythrocytes. Serology was nonreactive. Leukocyte count was 11,700 with neutrophils 74%, lymphocytes 17%, monocytes 4% and eosinophils 1%. Also reported were: Hemoglobin 12.6 grams; a sedimentation rate of 20 mm.; and a hematocrit of 40%. The blood sugar on admission was 185 mg%.

He was put on a sliding scale insulin dosage with regular insulin, based on the urinary sugar. On this management he required up to 80 units of regular insulin per day. His fasting blood sugar ran as high as 316 mg%. In consultation with the Medical Department it was decided to place him on a 2,000 calorie diet and try him again on NPH insulin. He was started with 30 units before his breakfast with supplemental doses of regular insulin at noon, supper and bedtime. On December 9, 1959 incision and drainage of the cellulitis was done by Doctor Henry J. Biermann of the Department of Surgery. Culture of the pus showed aerobacter aerogenes; hemolytic pigment forming coagulase positive staphylococcus aureus. Patient was treated with large doses of penicillin, novobiocin and tetracycline. Gradually the infection in the hand was brought under control and good healing was obtained. On December 22, 1959 he was transferred to the Medical Service for further management of his diabetes and nephritis. By this time the patient's appetite had become very poor. He refused food and

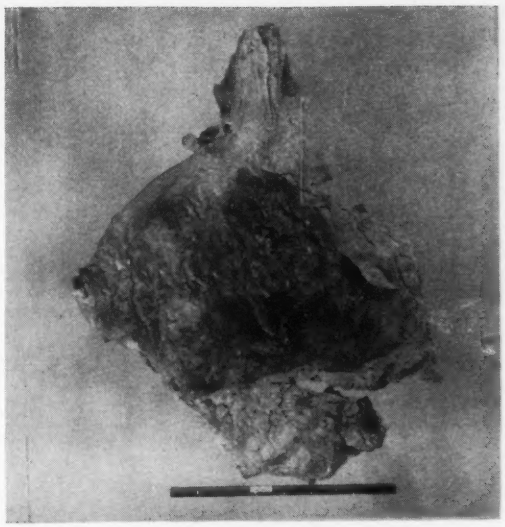

Figure I. Stomach and distal esophagus. There is marked necrosis of the mucosa and wall of the stomach which is extremely friable. This is the picture of phlegmenous gastritis.

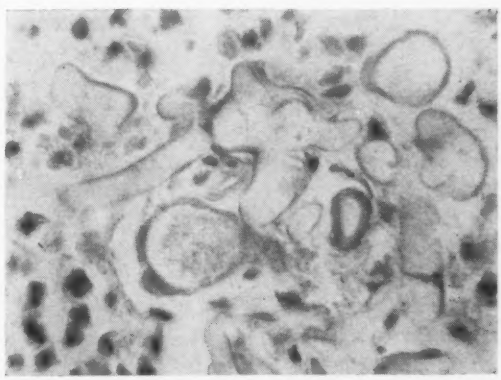

Figure II. Stomach. Fungi displaying the characteristic morphology of mucormycosis are easily identified. Hematoxylin and Eosin.

had to be maintained on parenteral fluids. He was again placed on a sliding scale of regular insulin. Blood non-protein nitrogen at this time was 169 mg%. Blood pressure was 200/120. His course continued downhill with progressive increase in coma until he expired on January 10, 1960. At no time during his hospitalization did the patient show any abdominal distention or rigidity.

At autopsy the gross findings showed a generalized peritonitis with abscess formation. This involved the area of the stomach and pancreas and down into the pelvis where there were loculated abscesses. The stomach was involved in a phlegmonous process that had reduced the stomach walls to tissue paper thinness. The serosal surface of the stomach was covered by a thick fibro-plastic yellow exudate. On opening the stomach the mucosa was hard to recognize. It was covered with a shaggy, yellowish-black material and the wall was markedly thin. In a few areas the wall was tissue paper in thickness. The kidneys were slightly enlarged with finely granular external surfaces. The capsule stripped with ease. On the cut surface the cortices were pale, bulged slightly, but no abscesses were noted. Calices were not dilated.

On microscopic examination the pancreas was markedly distorted by virtue of inflammatory reaction. The inflammatory reaction varied from acute to chronic in nature and was frequently associated with marked fibroplasia. Numerous areas associated with the inflammatory reaction were noted. There were numerous thick septate hyphae as well as atherospores consistent with mucormycosis. The extraneous tissue showed dilatation of the acini and some atrophy. The islets showed marked hyalinization. Sections of the stomach showed almost complete distortion of the structures. There was an acute purulent inflammatory reaction with marked necrosis of all layers from mucosa to the serosal aspect. The inflammatory reaction in some areas was scant while in others it was teeming with polymorphonuclear leukocytes. There were numerous hyphae and spores similar to those noted in the pancreas. These same organisms were seen in the blood vessels.

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AMA Endorses Blue Shield

Relaxing a long-standing policy of neutrality in the Blue Shield vs. commercial insurance battle, the A.M.A's House of Delegates formally recognized Blue Shield as a "proper economic arm" of the medical profession during its annual meeting in Miami Beach.

"Blue Shield plans need and deserve the support of physicians and medical societies," according to the approved report of the Council on Medical Services, and physicians are urged to participate. Also mentioned in the report were "improvement and expansion of benefits" and "cooperation in preventing abuses of the patient, physician and plan."

According to John Castellucci, Executive Vice-President of the Blue Shield Association, the report "puts us in a good position to be more flexible in expanding our benefit structures." It is anticipated that Blue Shield will attempt to use the cooperative spirit of the report to expand its chief competitive weapon—service benefits. But indications are that it will be a slow, hard fight despite the commendatory nature of the AMA report.

Author describes a substitute urinary bladder with near perfect continence created from a loop of the distal ilium. Urine emerges via normal channels.

A Substitute Urinary Bladder With Continence*

CHARLES L. REYNOLDS, JR., M.D.

Charles L. Reynolds, Jr., M.D., graduated from the University of Texas, Southwestern Medical College in 1949. After practicing in Weleetka and Okemah, Oklahoma, Doctor Reynolds returned to his school of graduation in 1955, where he completed a one year residency in general surgery and three years in urological residency. Since July, 1960, he has been in private practice in Oklahoma City.

Doctor Reynolds is a member of the Oklahoma Urological Association, the Texas Urological Association, an honorary member of the Mexican Urological Association and a Fellow in Surgery at the University of Texas, Southwestern Medical College.

THE PURPOSE of our study was to determine the feasibility of utilizing a segment of distal ileum for the creation of a continent internal urinary bladder and to study the changes produced by intermittently sacrificing and observing the animals over a period up to three years.

Historical

The first attempt at such a procedure was made by Tizzoni and Foggi[5] in 1888, who succeeded in creating continent substitute bladders in two dogs by isolating a segment of small bowel and interposing this between urethra and the skin. The ureters were implanted into the wall of the segment. The cutaneous openings were later closed. Though no chemical or pathologic studies were made, the dogs were alive, well, and voiding spontaneously with continence two months later. Apparently this concept for the use of ileum remained relatively forgotten until Bricker[1] reported his famous blind loop ileostomy for urinary diversion. Pyrah[2] then became interested and performed an operation aimed at creating a continent internal bladder in a one stage procedure by utilizing a twenty-two inch segment of distal ileum, anastomosing the ureters bluntly into the two ends and attaching the ante-mesenteric center of the loop to prostatic urethra. His patient is at present alive and well, continent in the daytime but not at night. The chemistries have remained normal.

Operative Procedure

Our experimental study on twenty dogs consisted of performing both single and dual stage operations with a variety of ureteral anastomoses.[4] The one stage operation consists of a cystectomy after which a segment of distal ileum approximately ten inches long is isolated and the bowel reanastomosed. Both ends are closed and urethra is anastomosed to the ante-mesenteric center of the segment. The ureters are attached to the segment on each side of and two inches from the urethra. A specifically devised

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Acknowledgments: This project was carried out at the Veterans Administration Hospital, Southwestern Medical School, University of Texas. Research aided by grant from the U.S. Public Health Service. We wish to express our appreciation to Mrs. Frances Jay for her secretarial assistance.

ureteral anastomosis to which we accord considerable significance was used in addition to a variety of tunneling anastomoses. The special anastomosis consists of a blunt end to side attachment into the segment in the above described location. In addition, the adventitia of the ureter is sutured to the serosa of the segment for a distance of 1½ inches, making sure that the ureter is at right angle to the long axis of the loop. This provides a sphincteric action in that as the segment expands with urine, the ureters flatten and become more angulated. As contraction occurs the attached ureters bend and kink. Either situation is less conducive to ureteral reflux. The two stage operation is identical except that the distal end of the loop is brought out to the skin for continuous drainage. The cutaneous opening is closed at a later date.

Results: One Stage Procedure

Eleven dogs underwent a one stage procedure. Five had a tunneling type of ureteral anastomosis, and all died of uremia following stricture formation with subsequent hydronephrosis. The three surviving animals had the special ureteral anastomosis we have described. After one week continent voiding without residual occurred. Reflux was absent and post mortem retrograde pyloureterograms revealed little or no dilation of the upper tracts. Discharge of mucus was enormous, requiring repeated irrigations to prevent obstruction. Chemistries remained normal* The animals were sacrificed after three months and gross pathologic examinations revealed an abundance of mucus in the new bladder but no dilation or stricture formation of any portion of the genitourinary tract.

Results: Two Stage Procedure

In nine dogs undergoing two stage procedures, four deaths occurred. Again the five surviving animals had the previously described ureteral anastomosis. Following closure of the cutaneous openings of the segments, continent voiding without residual began immediately. Cystometrograms performed on three of the animals revealed bladder capacities of about 120 mls., with forceful kickoff at volumes of from 100 to 120 mls. Cystograms revealed evidence of reflux in two animals on one side only. Chemistries remained normal. A striking fact was that after three to six weeks very little mucus was produced and this permitted us to close the cutaneous openings. After closure formation of mucus was not a problem. The animals were sacrificed at intervals of from three to seven months and practically no mucus was found. No gross pathologic changes were noted.

Two Stage Procedure in Man

On the basis of our experimental work we felt justified in performing the two stage operation on man. To date, two such procedures have been performed. One was upon a 38 year old white male, who for ten years had progressive leukoplakia of the urinary bladder with scattered islands of cystitis glandularis and a bladder capacity of from 30 to 40 mls.

This man is now 2½ years postoperative and still carries no residual urine. Mucus is not a problem. Reflux is now evident on the right but this does not seem to precipitate acute infections. Excretory urograms reveal some dilation of the right pelvis and ureter but none on the left. The chemistries remain normal and the urine sterile, though a few pus cells are noted in the midstream urine. There has been no change in the bladder capacity of 175 mls., and the patient is continent except for bedwetting one time nightly.

The other patient, a 69 year old white male had a grade IV, stage B-2 transitional cell carcinoma of the bladder just above a ureteral orifice. Cystectomy and a two-stage procedure were performed with one difference and that is that both ureters were implanted into the isoperistaltic side of the ideal segment. Two attempts were required to close the ileostomy opening. The patient had a stormy postoperative course because of the development of hepatitis. He is now one year postoperative, has reflux on the left side and no residual urine. The bladder capacity is 200 mls., the urine is sterile but contains a few pus cells. The

*Routine chemistries included carbon dioxide combining power, chlorides, blood urea nitrogen, creatinine, sodium, potassium, and phosphorus.

excretory urograms reveal minimal dilation of the upper urinary tract. Mucus is not a problem. I do not know how long we will be able to follow this man because he now has cirrhosis of the liver, possibly secondary to the hepatitis.

Dogs—Long Term Follow Up

Five dogs were prepared by the two stage procedure for long term follow up. Two of the animals died at 9 and 12 months, respectively, from causes other than the urinary tract. Two animals were sacrificed after two years and were found to have normal urinary tracts. The substitute bladder contained scattered islands of transitional epithelium, apparently creeping upward from the urethra on an intact viable basement membrane from which most of the original mucosa had sloughed.

The fifth dog is now nearly three years postoperative. He is a healthy, happy farm animal which I have not sacrificed.

All five of the animals appeared to be continent and to maintain sexual potency. None were bothered by mucus. The chemistries remained normal.

Summary and Conclusions

The conclusions of the original papers[3,4] still hold in that the two stage procedure appears to be the operation of choice because of mucus. Optimum time to close the cutaneous opening is when the secretion of mucus has diminished, chemistries have stabilized, and any temporary dilation of the upper urinary tract has subsided. The specially devised ureteral anastomosis seems superior in that a blunt end to side junction avoids stricture formation while its long attachment to the segment affords a sphincteric action. The peculiar pseudomembranous necrosis of the mucosa is clinically beneficial in that there is corresponding decrease in the mucous secretion.

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Outlook on H.R. 10

H.R. 10, the Smathers-Morton-Keogh-Simpson Bill, is now awaiting its fate in the U. S. Senate. After previously passing the House of Representatives, the tax equity measure for the self-employed then went to the Senate Finance Committee, where it was amended to overcome objections by the Treasury Department. If passed by the Senate in its amended form, it will have to go back to the House for final approval.

The Senate, which began intermittent debate on H.R. 10 on June 29, failed to act before the recess, will resume debate on August 8. Although a number of amendments were being proposed on the floor of the Senate which could sidetrack the measure, it is reported that seventy senators favor it in its present form.

As presently constituted, the bill permits self-employed persons a tax-deferred setaside of 10% of annual income up to $2500 per year. The money could be placed with a bank or other fiduciary, as trustee, invested in insurance annuities, or in a new series of U. S. Bonds. Income tax would not be paid until the money is withdrawn, at a rate determined by the person's tax bracket at that time.

Employees of the self-employed person who have three years' tenure, must be provided for, with the employer's contribution based on a percentage comparable to contributions made in his own behalf.

Phenylketonuria in Oklahoma

LUCIUS WAITES, M.D.

THOMAS O. NICKLAS

Since graduating from the University of Tennessee College of Medicine in 1947, Lucius Waites, M.D., has limited his practice to Pediatric Neurology. He is certified by the American Board of Pediatrics. Doctor Waites is Assistant Professor of Pediatrics and Neurology at the University of Oklahoma School of Medicine.

Thomas O. Nicklas is a third year medical student at the University of Oklahoma School of Medicine and trainee, USPHS, Grant No. 2B-5266.

A PRELIMINARY SURVEY of phenylketonuria (phenylpyruvic oligophrenia) in mentally retarded individuals in the State of Oklahoma has been completed. The study included Enid State Training School, Pauls Valley State Training School, Western State Hospital, Eastern State Hospital and Taft State Hospital. A previous survey had been completed in Central State Hospital and is included.[1] Most of the Special Education Classes for the trainable group were surveyed but the educable students remain to be checked. Some private institutions for the mentally retarded were also included. In summary, the survey of the high-risk group has been completed but the lower-risk group study will be completed in the near future.

The following table lists the number of patients that were evaluated and the age group of these individuals:

Total Number	4470
Individuals over 14 years of age	2650
Individuals under 14 years of age	1820
Total Number of Individuals with Phenylketonuria	21

The oldest patient in the series with phenylketonuria is a 78 year old female and the youngest patient with phenylketonuria is a 5 year old female.

The diagnosis was made by observing the reaction of a fresh aqueous ferric chloride solution (10%) with the urine. A positive reaction is denoted by a blue-green color within one minute after the ferric chloride solution has been added to the urine, or a few drops placed on a wet diaper (diapers may be used that have not been dry from the urine for more than six hours). Some substances in the urine give a purple reaction, but this is never found in phenylketonuria. Dinitrophenylhydrazine and Phenistix* were employed in some parts of the study but were not used routinely.

There were four individuals with phenylketonuria in whom therapy was indicated, and they are under observation and treatment. The treatment consists of proper dietary regimen low in phenylalanine content.

*Ames Company

As ten to twenty per cent of the patients with phenylketonuria are generally missed in a single urine analysis, continuation of this study is planned.

Comment: The main purpose of this study is the prevention of mental retardation. Phenylketonuria is an inheritable disease which follows a recessive pattern. Therefore, the relatives of the patients must be made aware that the condition may recur. They must understand that this type of mental retardation can be prevented by treatment begun in early infancy. All families of individuals with phenylketonuria in this survey have been informed of this condition, and of the possibility that it may recur in infants born of relatives. They have been encouraged and advised to seek immediate medical aid for any infant who is not developing properly.

Every infant who is not developing normally, either by history or examination, deserves a urine analysis for phenylketonuria.

(Miss Mary Crossley, a high school senior in Del City, checked the urine of 510 normal high school students, and 40 mentally retarded students in a special education class in Midwest City. She found one patient in the mentally retarded group with phenylketonuria, and this is one of the four now under observation and treatment. Her study was part of a high school science project and she is to be commended for her endeavors.)

(Aided in part by support from the MCH Division of the Oklahoma State Department of Health for the first two months of the study.)

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With the advances in open heart surgery, diagnostic methods for the evaluation of acquired valve lesions are needed. A technique to study the heart's left sided hemodynamics is presented.

Left Heart Diagnostic Method*

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Gerald L. Honick, M.D., graduated from the University of Oklahoma School of Medicine in 1953 where he is now a Research Fellow in Cardiology.

WITH CONTINUED ADVANCES in open heart surgery attention is now being directed toward correcting lesions as well as the congenital defects. This necessitates accurate pre-operative evaluation. For instance, when considering a patient for mitral valve surgery, the mere suspicion that stenosis or insufficiency predominates is not accurate enough. If mitral regurgitation is significant open heart surgery is required instead of the ordinary mitral commissurotomy.

Left heart catheterization by the paravertebral,[1] transbronchial,[2] supersternal,[3] or transseptal[4] techniques gives left atrial pressures and diastolic pressure gradients across the mitral valve which are helpful in mitral stenosis, but frequently are less helpful in mitral insufficiency. A left ventricular angiogram is an important procedure in evaluating mitral insufficiency. Various techniques have been described for doing left ventricular angiograms. Injection of contrast media through a needle directly into the left ventricle has caused deaths in 85 cases.[5] Also a subxiphoid approach in which the needle traverses the right ventricle and the septum into the left ventricle has resulted in three deaths in 77 cases.[6] Inadvertent intramyocardial injection of contrast media was the cause of deaths.

In 1950 Zimmerman introduced a catheter into the left ventricle by way of the aorta, passing the aortic valve in a retrograde fashion.[7] Amplatz introduced a large catheter in the femoral artery which was advanced to the ascending aorta.[8] In the lumen of the catheter a two or three inch flexible, tightly coiled spring on the distal end of a wire stylet was advanced beyond the end of the catheter. During fluoroscopy the spring was maneuvered at the aortic valve and entered the left ventricle. The catheter was then slipped over the spring stylet into the left ventricle and the stylet was removed. The catheter had multiple side holes which allowed for an even injection of contrast media with little danger of injecting into the myocardial wall. Dotter, using Seldinger's technique, has described a similar method using a spring.[9] Lambert and Vlad reported 117 cases of left heart catheterization by the retrograde technique and were successful in 90 per cent of the cases.[10] Five of the twelve failures were due to aortic stenosis. However, of eleven cases of aortic

*Presented at the Oklahoma County Heart Association, January 25, 1960.

stenosis, six were successful. Forty-one times they attempted to enter the left atrium from the left ventricle and were successful in fifty per cent. They reported no complications. Green, Ziegler, and Kavanagh-Gray were successful in entering the left ventricle in 88 per cent of 100 cases using this technique.[11] They think that most often the cause of failure is due to marked dilatation of the aorta or difficulty in entering the ascending aorta.

Sones has done many left heart catheterizations by this retrograde technique and rarely was unable to enter the left ventricle.[12] A spring was not used with the catheter. Instead a Rodriguez Alvarez catheter (closed tip, six side holes) was inserted in the right brachial artery and passed into the ascending aorta. His technique is to form a small loop in the distal end of the catheter which allows the aortic cusps to catch this loop during systole. Then the tip can be manipulated into the ventricle. However, with aortic stenosis the tip of the catheter must enter directly into the left ventricle without the benefit of a loop. While attempting to accomplish this in a patient with aortic stenosis the catheter followed the wall of the aorta and consistently stayed in the dependent sinus of Valsalva. It was impossible to move the catheter tip in any other location. Thus it appeared that if one could direct the catheter tip perpendicular to the center of the aortic valve there would be greater chance of success. By molding the catheter tip into an elongated S-shape it was hoped that this bend would lift the tip away from the wall. Ten of the eleven attempts using this type catheter have been successful. Experience in the future may show that this modification may not be necessary.

In brief, acquired valve lesions can be adequately studied by the following procedures. In suspected cases of mitral stenosis, with a catheter in the left ventricle and a good pulmonary wedge pressure, the mitral valve gradient is obtained. If stenosis is shown, contrast media can be injected into the main pulmonary artery and will demonstrate the size of the left atrium, movement of the valve leaflets, and the prolonged opacification of the left atrium. If mitral insufficiency is suspected, contrast media can be injected into the left ventricle, rotating the patient in the right anterior oblique position and then estimating the amount of regurgiated media. In aortic stenosis, contrast injection is not so important since the valve gradient is easily obtained, but injection into the left ventricle would detect the rare case of subaortic stenosis. Contrast media can be injected 2 cm. above the aortic valve in order to estimate the amount of aortic insufficiency. One occasionally may also see the coronary arteries from this injection.

Another challenging aspect of acquired heart lesions is coronary artery disease. Everyone would agree that prevention is the solution to the problem, but maybe in the future there will be isolated indications for surgical treatment when coronary lesions are detectable.

It is not simple to demonstrate the coronary arteries radiographically. When one considers that the blood flow through the ascending aorta is at the speed of 100 to 150 cm. per second, one can appreciate how rapidly a small amount of radio-opaque medium can be swept away from the coronary ostia. But using thin walled catheters with multiple side holes, pressure injector syringes, and contrast medium heated to lower viscosity, one can get a sufficient quantity at the coronary ostia to make the studies successful.

Arnulf uses transient cardiac arrest produced by acetylcholine.[13] The prolonged diastole improves coronary visualization. Another method is described by Dotter, visualizing the coronary circulation by occlusion aortography.[14] A double lumen catheter is used in which one lumen connects to a latex balloon inflated with nitrous oxide or cardon dioxide in the ascending aorta. With the aorta occluded, contrast media cannot be swept away, thus giving excellent coronary visualization. It is difficult to keep the inflated balloon in the ascending aorta since this tends to be propelled distally. Also the tremendous increase in intra-aortic and intraventricular pressure could be quite dangerous.

Sones has visualized the coronary arteries in over 100 patients by using cineangiocardiography.[12] He manipulates a Rodriguez Alvarez catheter so that the tip is lying in the right or left sinus of Valsalva near the coronary ostia, making sure that the pressure is not damped and that he has not entered the coronary artery. Positioning the patient 30 to 40 degrees LAO the left main, circumflex and anterior descending coronary arteries are best visualized avoiding the superimposition of the spine. Twenty-five mls. of 90% hypaque are injected in this sinus under a pressure of five kilograms per centimeter square. With the catheter in the right sinus a similar injection is made 60-70 degrees LAO. At the present time he is working on another technique in which a small catheter is manipulated approximately one-half inch inside the coronary artery and requires only 3 to 7 mls. of contrast media to be injected by hand into the coronary artery. He thinks that by this method the best visualization is obtained.

With the development of a reliable technique in demonstrating coronary vessels new opportunities arise for further investigations of coronary artery disease.

Summary

The diagnostic approaches to acquired heart lesions are discussed, elaborating on catheterizing the left ventricle by passing the catheter retrograde across the aortic valve.

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49% of Aged Covered

Forty-nine per cent of all Americans 65 years of age or older have health insurance, Health Insurance Association of America reported.

It is estimated that by 1970 some 90% of the aged *who need and want* this protection will have it. Of the 15.7 million in the 65-and-over age group, an estimated 7.7 million had health insurance on January 1, 1960.

The analysis, first of its kind made on a nationwide basis since early 1958, was based on coverage trends revealed in government and private surveys and on developments in the health insurance business.

Growth of health insurance protection among the elderly during the past eight years has been at a more rapid pace than for the population as a whole. In 1952, one of four senior citizens had health insurance. Now one out of two are so protected. Over the same period, growth in coverage for the total population was from nearly six out of 10 to a little more than seven out of 10.

In addition to the 49% of the 65-and-over who now have health insurance, another 15% (2.4 million) are officially classified as indigent, and provision is made for their medical needs through Old Age Assistance.

MEDICAL CENTER

Message from the Dean

Just as a tree or shrub needs three elements—climate, space, and nutriments—for its proper growth and development, there are three similar elements in the proper growth and development of an institution such as the University of Oklahoma Medical Center. And just as a tree or a shrub will become stunted or mis-shapen and poorly developed if any of the elements are missing, there will be an imbalance in an institution if there is not an adequate supply of the three requisites.

The academic and professional climate is excellent and will probably continue to be if other elements are provided.

The University of Oklahoma Medical Center has reached the point of diminishing return in a more intensified use of its physical space, both within the existing buildings and in the land area available for future buildings. The land for the University portion of the Medical Center has been decreased by allocations to the Oklahoma Medical Research Foundation and the Veterans Administration Hospital. The inevitable further crowding of the University portion will also affect the operation of the other components.

Large portions of the existing space in the present hospital buildings are no longer suitable for use as a teaching hospital. The cost of converting them to modern hospital facilities would be very considerable, but they are adaptable to other Medical Center uses, providing new hospital areas are constructed. The existence of two separate hospital buildings has always hampered the efficiency and economy of operation. The logical answer is the construction of a modern teaching hospital, designed and equipped for this specialized purpose. Such a facility intensifies the need for additional campus.

With the exception of the student nurse dormitory, the University of Oklahoma Medical Center has not been provided with housing or recreational facilities for Medical Center students. Dormitories, too, require land for site and service areas. These, and similar problems, make the acquisition of additional land, contiguous to the Medical Center, a top priority project.

The proper nutrition for the Medical Center is an adequate operating budget to provide reasonably competitive salaries, modern equipment, and adequate supplies for the operation of the School of Medicine, School of Nursing and the University Hospitals. This element for growth and development has been insufficient for the Medical Center. Competition for the too limited supply element is exceedingly great among the institutions and agencies in Oklahoma. If the Medical Center is to receive its needed share, friends of the institution must see that many of our citizens are properly informed as to the needs and the importance of fulfilling them, and thus prevent ramifications of inadequate health care for the future citizens of Oklahoma. The Alumni Association of the School of Medicine has recently prepared a comprehensive recommendation on this subject which will be made available during the coming months.

Mark R Everett

Medical Grand Rounds

Thomas N. Lynn, Editor,
Chief Medical Resident, University Hospital, Oklahoma City, Oklahoma

Bert Sears, M.D., Discussant,
General Practice Resident, University of Oklahoma Medical Center

Wyman Ewing, M.D., Discussant,
Radiology Resident, University of Oklahoma Medical Center

H. Earl Ginn, M.D., Discussant,
Medical Resident, University of Oklahoma Medical Center

Isadore Snapper, M.D., Discussant,
Chief of the Medical Service, Beth-El Hospital, New York City, New York

Doctor Bert Sears: Our patient is a 69 year old white male retired shoe salesman, whose first admission at the University of Oklahoma Medical Center was on 1-19-59, with the chief complaint of weakness, swelling and pain in the joints, and swelling in the hands, face and feet of one month's duration. Approximately one month prior to his admission the patient had noticed the onset of swelling and redness around both eyes. This was followed in the next few days by swelling and inability to bend the right knee. He then developed mild arthralgia of the ankles, and noted some pain on movement of the shoulder, elbow and wrist joints. About two weeks prior to his admission he began having some difficulty in swallowing solid foods and he developed a cough which was productive of one to two cups per day of thick whitish sputum. Also, about two weeks prior to admission, he became aware of orthopnea which progressed to the extent of using four pillows for sleep by the time of admission. During this two to three weeks, he ran a low grade temperature, said to have been no higher than 100 degrees, and he had been told by a physician that he had protein in his urine. The pertinent past history included "chronic sinusitis" which he dated to sometime in his twenties, manifested by rhinorhea, post nasal drip, and frequent sneezing in the summertime. There was also a history of frequent "hives" and rashes, sometimes associated with the ingestion of strawberries and tomatoes. He had developed a morbilliform rash in 1952 after receiving a penicillin injection. He told of having a myocardial infarction in 1952 which was treated by six to eight weeks of bed rest and from which he recovered uneventfully. The Review of Systems was not otherwise remarkable except for occasional exertional dyspnea, and some swelling of the legs and feet which he attributed to standing for long hours.

Physical Examination: Physical examination on admission showed a blood pressure of 120/70 mm Hg, a pulse rate of 120 per minute, a temperature of 100.2° F., and a respiratory rate of 18 per minute. He was well developed and well nourished, but appeared moderately acutely ill. He spoke with a wavering voice, but with adequate articulation. The eyes exhibited bilateral periorbital edema, conjunctival injection and increased lacrimation. The pupils reacted normally. The fundi showed attenuation of the

arterioles, with cytoid bodies along the upper nasal arteriole in the right eye and some exudate in both fundi. There was hyperemia of the nasal mucosa, sublingual mucosa and pharynx. The chest was symmetrical with equal expansion bilaterally. Moist rales were heard in both lung bases posteriorly. Examination of the heart showed a regular rhythm at 120 per minute, no cardiomegaly, and a grade 11 early systolic murmur at the cardiac apex. The liver was palpable 2 cm. below the right costal margin and was smooth and nontender. On examination of the back, presacral edema was noted. The hands and shoulders were noted to be weak and a course tremor of the hands was noted. There was moderate pitting edema of both hands and feet, and there was increased warmth over the wrists, elbows and knees but no obvious hydrarthrosis or erythema. The peripheral pulses were normal except for the popliteal and dorsalis pedis pulses which were diminished bilaterally. Neurological examination was normal.

Laboratory Data: The white blood count was 11,900/mm^3 with 65% neutrophils, 30% lymphocytes, 1% monocytes and 4% eosinophils. The hemoglobin was 13.1 gms.%, the hematocrit 47%, the erythrocyte sedimentation rate 36mm/hr. (Wintrobe), and the serological test for syphilis was negative. Subsequent hemograms consistently showed a leukocytosis of between 10,000 and 17,000, usually with a normal differential count but occasionally with a shift to the left. A total eosinophil count was 300/mm.^{3} During the hospitalization, the hemoglobin fell to 8.7 gms. and the hematocrit to 32%. The red blood cells were thought to be normocytic and hypochromic and some basophilic stippling was noted on peripheral smear. Two bone marrow examinations were nondiagnostic. The serum iron was 73 micrograms %, two Coombs tests were negative, and a red blood cell survival time was within normal limits. The BUN was 21 mg. %, and the admitting urinalysis showed a positive protein reaction and 8 to 10 fine granular casts per high power field. Repeat urinalyses showed persistence of the proteinuria, casts and white cells. PSP excretion was 13.5% in 30 minutes, and on a Fishberg concentration test, the maximum specific gravity obtained was 1.018. Creatine excretion was 0.2 gms. per 24 hours and creatinine excretion was 0.7 gms. per 24 hours. An intravenous pyelogram showed poor excretion of dye bilaterally but was otherwise normal. Urine cultures were positive for paracolon bacteria on three occasions, and a needle biopsy of a kidney was nondiagnostic. Liver function tests showed a total serum protein of 4.5 with an albumin of 2.3 gms. %. The thymol turbidity was 12 units. There was 15% retention of BSP dye in 45 minutes, the cephalin flocculation was 4 plus in 24 hours, the alkaline phosphatase was 4.7 Bodansky units and the prothrombin time was normal. The serum glutamic oxaloacetic transaminase was 110 units. Peritoneoscopy was performed and was considered to be normal. A biopsy of the liver showed only marked fatty change. A chest x-ray taken on admission showed a patchy infiltrate at both bases and a right pleural reaction, and a subsequent chest film showed a small amount of fluid in the right pleural space. A thoracentesis was productive of 130 cc. of clear yellow liquid with a specific gravity of 1.011, and a total protein of 2 gms.%. Cytologic study of this fluid was negative for malignant cells. Bacteriologic studies, including those for acid fast organisms and fungi were negative on the pleural fluid, sputum and gastric washings. PPD No. 2 skin test was positive, and a pleural biopsy showed "chronic pleuritis." An electrocardiogram showed an old inferoseptal and postero-lateral myocardial infarction with peri-infarction block. Serum electrolytes were normal, as were calcium and phosphorous determinations. Six slides for the demonstration of "L.E." cells were negative, as were two attempts to demonstrate Bence-Jones protein in the urine. A latex agglutination was reactive on one occasion and not on another. Urine examinations for lead and arsenic were within normal limits. Most of the stool examinations for occult blood were positive. Blood cultures were negative. A skin muscle biopsy taken from the thigh was reported to show slight chronic inflammation around the blood vessels and some degeneration of the fibrous tissue in the deeper portion of the skin.

Hospital Course: He was initially treat-

ed with bed rest, low sodium diet, and digitalization which resulted in a substantial weight loss. His temperature spiked daily to about 100° F. during the first two weeks of hospitalization after which time it subsided spontaneously and remained normal throughout the remainder of his hospital stay. Following admission the patient developed considerable muscular weakness which became so marked by the end of the fourth hospital week that he was unable to get out of bed or even lift his legs off the bed. Prednisone therapy was started during the second hospital month, and following this, he experienced a gradual increase in strength, and by the fourth hospital month he was walking with the aid of a cane. Also, by the fourth month, the rales in the lungs had disappeared and the hemoglobin had returned to 10.7 gms.%. The abnormal shadow noted on the chest film progressed through the first two and a half months then regressed. He was discharged at the end of the fourth hospital month taking 15 mgs. of Prednisone and 1 mg. of digitoxin daily and ferrous gluconate. In the clinic, an attempt was made to decrease his meticorten. When it was dropped below 10 mgs. per day, he experienced a recurrence of weakness and edema of his legs and feet. At the present time, he is still being followed in the clinic and presents no laboratory or clinical findings significantly different from those previously mentioned.

Doctor Wyman Ewing: We have films of barium enema, upper GI series and skull films, all of which are completely normal. The chest films, of course, are of greatest interest. On the first film the heart was noted to be at the upper limits of normal in size, and there was a bilateral lower lobe pulmonary infiltrate. This infiltrate progressed and during the third hospital week, we noted that it was slightly more extensive, and at that time we noticed air beneath the diaphragm on both sides with some collapse of the lungs. The costophrenic angles were obliterated, suggesting the presence of fluid. Again the heart was noted to be at the upper limits of normal. I presume that the air beneath the diaphragm was due to the peritoneoscopy, since it correlates in time. In any event, this was not present on the next film. Films obtained during the ninth hospital week show that the infiltrate in the right lower lobe was much more dense, and had the appearance of an almost solid mass which may represent fluid or pleural reaction; the left lung was clearing somewhat on this film. The film obtained during the fourth hospital month shows almost complete clearing of both lungs. The last film we have was taken six months following discharge and we again see that the lungs were almost completely clear except that we do notice a slight patchy infiltrate near the costophrenic angle. The heart has, through all these films, varied somewhat in its size, but generally, has remained at the upper limits of normal.

Doctor Stewart Wolf: Doctor Ridings, have you any comment?

Doctor R. Ridings: I really can't add too much specific except that certainly on the later films and somewhat on the early films, this was not a generalized pulmonary affair. Both times it was limited to lung bases which could be related to heart failure, of course, but is not at all typical because the pulmonary vessels in the upper lobes look normal. In the later films, it certainly appears to be infiltrate rather than vascular.

Doctor Wolf: Would you comment further on the renal biopsy, Doctor Ginn?

Doctor Earl Ginn: The sections from the renal biopsy showed a slight thickening of the small vessel walls and also very mild thickening of the glomerular basal membrane. These changes were non-specific and there was nothing diagnostic on the renal biopsy. There was one very small area in the biopsy that had looked like an inflammatory reaction. The patient could have pyelonephritis and we have missed the major pyelonephritic area with the biopsy needle.

Doctor I. Snapper: The history, the physical examination and the laboratory data which have been presented all point to the presence of dermatomyositis. In this respect, especially the periorbital swelling and redness, both frequent occurrences in dermatomyositis, must be emphasized. Just as in the case in today's patient, the peri-

orbital discoloration often spreads over the rest of the face, sometimes even over the neck and the trunk. Ultimately, the color changes to a violet of heliotrope hue. In modern times the designation "lilac disease" is often used instead of the old term dermatomyositis.

A second strong point in favor of the diagnosis of dermatomyositis is the presence of cytoid bodies in the eye fundus. These so-called bodies occur not only in dermatomyositis but also in lupus erythematosis, occasionally even in polyarteritis. The designation "cytoid bodies" should be used only if yellowish fluffy lesions are discovered, situated *anteriorly* to the blood vessels. All other retinal exudates are located posteriorly to the vessels. In addition, there is also a histological difference. Cytoid bodies are degenerated proliferating nerve fibers.

The waxing and waning infiltration of the right lower lobe, the weakness of the vocal cords, of the pharyngeal muscles, of the skeletal musculature and of the myocardium are all frequent manifestations of dermatomyositis. If possible, a final confirmation of the diagnosis should be obtained by a muscle biopsy. In dermatomyositis multiple lesions of the musculature are found but no truly *generalized* muscular disease is present. It is, therefore, necessary to choose carefully the location where the biopsy should be done. In the muscles underlying a skin lesion are clear cut pathological changes most likely to be found. As a matter of fact, the discoloration of the periorbital area is connected with the frequent involvement of the eye muscles. If no cutaneous lesions in the form of erythematous patches, erythema nodosum or erythema multiforme are present, then the biopsy should be performed in a muscle group which is hard and indurated. In this patient the biopsy was done in the quadriceps muscle. However, on palpation the musculature of the thighs does not seem to be indurated, whereas the calf muscles are very hard indeed. A biopsy of the musculature of the calf might well be revealing.

In dermatomyositis, as is the case in all degenerative and inflammatory diseases of the musculature, the urinary excretion of creatine is increased: usually more than 400 mgs. of creatine are excreted daily. The elimination of 200 mgs. of creatine, as present in this patient, does not exclude the presence of dermatomyositis, but decidedly does not favor this diagnosis. It must, however, be stressed that the colorimetric determination of creatine and creatinine in the urine is very poor indeed. Errors can easily occur. In addition, it is of importance that this patient eliminated on the day of the experiment only 0.7 grams of creatinine. This low value could indicate that the total 24 hours urinary output was not collected. However, in dermatomyositis, the urinary creatinine may be decreased because part of it may be excreted as creatine.

Unless this value of 200 mgs. is found repeatedly on consecutive days, the relatively small quantity of creatine present in one urine specimen should not be accepted as a strong point against or for the diagnosis of dermatomyositis. Special mention must be made of the atrophy and lack of elasticity of the skin of this patient which is highly reminiscent of scleroderma. This finding is far from inconsistent with the diagnosis of dermatomyositis. Actually, many clinicians consider that both diseases are identical. I too have frequently seen patients who were suffering from both scleroderma-like changes of the skin and concomittantly, from hardening of special muscle groups. However, until now I have only once been able to find a patient in whom the biopsy of the skin showed the presence of scleroderma, and the biopsy of a muscle the presence of dermatomyositis. All the other patients, even if clinically apparently suffering from a combination of scleroderma and dermatomyositis, always had either scleroderma or dermatomyositis.

Not only does the consistency of the skin of patients with dermatomyositis ultimately stimulate sclerodermatous changes, subcutaneous calcification which is so frequent in scleroderma, is also found in dermatomyositis. In children the subcutaneous calcinosis sometimes involves the whole surface of the body. Ultimately, these unfortunate children are completely incarcerated in a shell of calcium phosphate.

I would therefore conclude that in our patient with a heliotrope discoloration of the skin of the face, cytoid bodies in the fundus, weakness and induration of many different muscle groups, the diagnosis of dermatomyositis is mandatory.

Doctor John Schilling: Does this polymyositis involve the diaphragm and could this in any way be related to adjacent pleural and pulmonary reaction, or are these lung changes the pulmonary parenchymal components of the disease?

Doctor Snapper: If the myositis of the diaphragm would have caused the infiltration of the right lung, then the muscular disease would be only localized in the right, not in the left leaf of the diaphragm. This does not seem probable. Anyway, infiltration of the lung due to perivascular infiltration and even fibrinoid degeneration of the collagen fibers of the lungs is a frequent occurrence in dermatomyositis.

Doctor W. O. Smith: I saw this patient during his first few months in the hospital and at that time we were concerned with his renal disease and considered polyarteritis.

Doctor Snapper: Polyarteritis, lupus erythematosis and dermatomyositis form one group of vascular diseases in which many of the pathological findings are caused by the formation of auto-antibodies. As a matter of fact, at one time, these diseases were considered to be identical and to represent only different variants of one underlying allergic syndrome. The clinical separation of these three syndromes was restored only after Hargraves in 1947 discovered the presence of specific lupus cells in lupus erythematosis. It follows that in many cases it may be difficult to distinguish between these three diseases. I must repeat that the heliotrope discoloration of the periorbital area of the face, the cytoid bodies and the degeneration of many groups of musculature practically prove the diagnosis of dermatomyositis.

The chameleonic character of the symptoms and signs of polyarteritis is the reason why this diagnosis is made *too* often as an act of despair in mysterious cases which offer a seemingly insoluble diagnostic problem. The following symptoms and signs represent the characteristic manifestations of polyarteritis.

1. Leukocytosis, combined with eosinophilia
2. Hypertension
3. Splenomegaly
4. Abdominal colic
5. Polyneuritis

In my experience the diagnosis of polyarteritis should never be made unless at least two, better still three, of these five manifestations are present. Since this is not the case in our patient, I would not be inclined to consider the presence of polyarteritis.

Doctor Wolf: A question that I'm sure is in the minds of many here is the possibility of a relationship between dermatomyositis and an undetected carcinoma, particularly in view of the recent pulmonary infiltrate. Would you discuss the relationship of dermatomyositis to carcinoma in general and give us your thoughts?

Doctor Snapper: The incidence of malignant tumors in dermatomyositis has been observed by so many observers that the connection between the two diseases cannot be due to coincidence alone. In total, about 100 cases of this coincidence have been published. Whereas most authors are of the opinion that in 5 to 18% of patients with dermatomyositis a neoplasm develops, this coincidence occurred in one series in six of 14 patients. The neoplasm can be found in any organ of the body, lung, esophagus, stomach, colon, rectum, kidney, liver and gallbladder.

Even more interesting is a possible improvement in the different manifestations of dermatomyositis following the removal of the malignant tumor. However, Talbott and Moleres Ferrandis, in their excellent monograph on Collagen Diseases, after careful analysis of the literature, doubt whether this generally believed relationship between the two diseases actually exists. Under the circumstances, further carefully controlled clinical observations seem to be highly desirable.

Doctor Wolf: Is it not true that difficulty in swallowing is a very common feature of dermatomyositis and not of polyarteritis?

Doctor Snapper: In dermatomyositis, degeneration and inflammation of the musculature are especially localized in eye muscles, muscles of the trunk and of the proximal part of the extremities, also in the pharyngeal, laryngeal and cardiac musculature. Difficulty in swallowing is, therefore, commonly found in dermatomyositis though not as frequently as in scleroderma. However, in scleroderma the dysphagia is usually the only manifestation of involvement of the musculature whereas in dermatomyositis nearly always many different muscular groups are involved.

Digressing for a moment, another remarkable form of dermatomyositis may be mentioned. This form of dermatomyositis starts as a peracute fulminant ulcerative colitis with wide spread ulcerations of the skin of the lower abdomen, perineal and perivaginal areas. In these patients slight rubbing of the skin results in the sloughing of large pieces of epidermis.

Doctor Wolf: We don't often present an open and diagnostic problem at these conferences but today we were particularly privileged to have had with us a man who has had one of the richest experiences in medicine, not only because of his background and astuteness in the great bedside tradition in medicine, but also because of his own pioneering work in biochemical thinking and biochemical studies in disease mechanisms. I'm sure that our own concept of dermatomyositis and "collagen disease" in general has been enriched and broadened by your visit with us today. Thank you, Doctor Snapper.

800 N.E. 13th, Oklahoma City, Oklahoma

ABSTRACTS

Amenorrhea and Elevated Level of Serum Cholesterol Produced by a Trifluoromenthylated Phenothiazine (SKF 5354-A)

M. L. CLARK* and P. C. JOHNSON**

J. Clin. Endocrinology & Metabolism, **20**: 641-646, April 1960

The administration of 1 gm. per day of trifluorinated phenothiazine (SKF 5354-A) resulted in amenorrhea in 6 of 7 female patients, without a rise in urinary gonadotropin excretion. The drug also produced a rise in the serum cholesterol level. There was a slight depression of 24-hour thyroidal I^{131} uptake, but not sufficient to account for the increase in serum cholesterol concentration.

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The Erythropoietic Factor in Hypoxic Patients With Emphysema Without Secondary Polycythemia

WALTER H. WHITCOMB,* ROBERT M. BIRD,** PHILIP C. JOHNSON,*** JAMES F. HAMMARSTEN,**** and MARGARET MOORE*****

A.M.A. Arch. Int. Med. **103**: 871-5, June 1959

Experiments are presented which indicate that the plasma from patients who are hypoxic as a result of pulmonary emphysema but who have not developed secondary polycythemia contain quantities of erythropoietin greater than that seen in normal subjects.

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The Incidence and Significance of the Leukemoid Reaction in Patients Hospitalized With Pertussis

JACK D. WELSH,* WILLIAM F. DENNY,** and ROBERT M. BIRD***

South. Med. J. **52:** 643-9, June 1959

1. The incidence and significance of the leukemoid reaction in pertussis have been compared in two groups of patients. The first group consisted of 47 hospitalized patients seen between 1933 and 1943; the second, 127 patients admitted to the hospital since 1951.

2. There was found to be no significant difference in the incidence of the leukemoid reaction between the two groups. There was, however, a significant decrease in the incidence of complications and in the mortality rate in the group seen between 1951 and 1956. This improvement was seen almost exclusively in those patients not manifesting a leukemoid reaction.

3. In those patients whose leukocyte count was in excess of 50,000 per cu. mm., however, complications appeared with similar frequency in both groups and the mortality rate was not significantly different between the two.

4. It is inferred that the development of a leukemoid reaction in pertussis is of increasing importance in predicting a poor prognosis.

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Effects of Gastric Juice Fractions on Uptake Of Labeled Vitiamin B-12 by Rat Liver Slices

T. B. DRISCOLL,* J. A. FAULKER,** B. CARROLL*** and P. C. JOHNSON****

Proc. Soc. Exper. Biol. and Med., **101:** 336-340, 1959

Gastric contents from two subjects without pernicious anemia have been chromatographed on an IRC resin column. Five more or less well defined protein peaks appeared in the effluent. Each peak was capable of enhancing uptake of Co-60 Vitamin B-12 by the rat liver slice. Prior to fractionation and after these gastric fractions had been reconstituted, these gastric juices only produced inhibition of Co-60 Vitamin B-12 uptake by the rat liver slice at all concentrations tested. The effluent of these chromatographic separations of human gastric content produced three Co-60 Vitamin B-12 binding peaks. Destroying proteolytic activity of the gastric juice decreased the binding of one of these protein peaks but did not change the results with the liver slice. The enhanced uptake on the rat liver slice produced by these gastric juice fractions did not seem to be related to proteolytic activity or to their ability to bind Vitamin B-12.

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Following Massive Transfusions The Problem of Hemorrhage

ROBERT M. BIRD* and JAMES F. HAMMARSTEN**

South. Med. J. **52:** 887-9, Aug. 1959

1. Oozing may complicate conditions which necessitate massive blood replacement (i.e., greater than 2 500 ml. of whole blood).

2. The basic disease or the nature of the surgical procedure are of major importance in the pathogenesis of the oozing.

3. Blood replacement itself is not the sole cause of the hemorrhagic complication. Varying defects in the clotting mechanism have been demonstrated. The most common of these are low platelets, decreased fibrinogen and accelerator factor deficiencies.

4. If oozing develops and is thought to be associated with the transfused blood, it seems advisable to limit additional blood to that which is reasonably fresh and which has been collected in nonwettable containers. Specific defects should be treated when these are recognized. Human albumin solution may be of considerable help as plasma expander if used with other appropriate measures.

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Effect of Prolonged Thyroid Administration on Aged Male Rats

J. F. LHOTKA,* L. G. McARTHUR,** and A. A. HELLBAUM***

Nature **184:** 1149-50 (1959)

Male rats (400 gm.) were orally administered purified thyroid extract (Proloid) from 12 months to sacrifice at 21 months in three daily dosage series equivalent to 14, 60 and 240 mgm respectively for a 70 kgm. human. At necropsy all principal organs were grossly examined and routinely processed by the paraffin method after neutral formalin fixation. Sections were stained histochemically for neutral and acid polysaccharides and histologically for reticular, collagenic, and elastic connective tissues. Sections were then compared with untreated control sections and with each other as well as with sections obtained from I^{131} induced hypothyroid rats. Detailed examinations revealed that other than expected toxic alterations in the 240 mgm series there were no consistent pathological architectural variations in the connective tissues of these animals, in the vascular structures and in the general epithelial tissues. It would appear that induced hyperthyroidism under the conditions of this experiment has little effect on these tissues in the aged male rat.

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Special Article

The Structure of the American Way of Life*

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YOU HEAR a lot of people today asking: "What *is* the American way of life?" Some people say you can't define it; that it's an abstract term. The Socialists and Communists, who are trying to lead us away from the basic principles of the American way of life, make quite a point of the fact that there is a considerable difference of opinion on the question of what it is.

So let's build our own version of the American way of life, and submit it to our friends and neighbors as a good definition, one that can be accepted by all Americans. Did you know that the founders of America, when they came here from England seeking freedom and a better way of life first established a communal, or collectivist, economic system such as Communism creates? They did, both at Jamestown and Plymouth Rock.

Let's send our mind's eye back to Plymouth Colony. In December of 1620, 101 pilgrims from England reached the Atlantic Coast in the *Mayflower*. Their primary purpose in risking the great hazards of an Atlantic crossing and life in a primitive unknown land was to gain religious freedom for themselves.

They had no preconceived ideas about building a nation, a society, or a system of economics.

By common consent the colony's economic system was communal. The property was community property, or public property; owned in effect by the colony's government. The people worked together at assigned tasks. They shared and shared alike in the total production of the colony.

There was a common storehouse. Each family brought all its produce of whatever kind to the storehouse. The government of the colony allocated the goods on a basis of equal shares for all. This was the Christian spirit of sharing. Our forefathers were people basically motivated by Christian principles. Many of them felt that they could best progress under this communal economic arrangement and have full freedom also. They thought they had an ideal economic system.

Even among these dedicated Christians, however, with their great measure of freedom, the theory of government ownership of property, and communal living did not work in practice.

A few of the less industrious colonists discovered that no matter how little they produced and carried to the common storehouse, they still received a share equal with their neighbors! They began to loaf and shirk their duty. The industrious, seeing they were being made to support the slothful, began to slow down also. Well, as one family after another eased up on their work and

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the production of vegetables, grains and meat, the goods in the storehouse dwindled. In time, starvation threatened to wipe out the colonists.

The leaders of the colony despaired of their communal experiment. Instead of providing plenty for all, the collectivist system had produced only an equal distribution of poverty and stagnation instead of progress. Something had to be done to restore the energies of the colonists.

Either a way must be found to stimulate work and production through voluntary willingness of everyone, or the colonists would have to resort to the type of coercive measures, based on force. which had been a part of human history for thousands of years. The Plymouth colonists did not want to force their labor with police power. That was one way of doing it, but they believed that freedom was a Godly heritage for all mankind, and they had fled from the old to the new world seeking this freedom.

So when the communal or collectivist system carried them toward starvation, the governmental and religious leaders together proposed the establishment of the basic law of *private property* and the fundamental principle of *self-reliance*. This was approved by the people in Jamestown as well as in Plymouth Colony. Did it change things for the better? It certainly did! The change in ownership and responsibility from government to the individual citizen marked the beginning of progress in the colonies. The new economic system helped the new world to progress and expand.

But in time, as the colonies prospered, Great Britain applied heavy taxation without the consent of the Colonists, harsh laws restricting freedom, and finally military rule. The Colonists rebelled, the Declaration of Independence was written and signed, and war for Independence followed. After their victory, the Colonies began to shape up their way of life.

Fundamental Belief in God

The great keystone foundation for the new nation's structure of freedom was faith in God. The founding families were Christian people. A belief in God was the central motivation of their lives. The desire for spiritual freedom was a powerful factor in their coming to this new world. The way of life which they began to build had God and God's pattern for mankind as its great foundation. So this was the keystone of freedom.

But in the structure of a nation's government, freedom has to be spelled out. It must be woven into the very governmental structure itself or there is danger of losing it.

With the end of the Revolution, the American people established the Articles of Confederation under which the 13 independent states operated. But there were many serious weaknesses. Lacking prestige abroad, the central government had little power to enforce treaties with other nations, no power to levy taxes and no power to regulate commerce. Many people felt that they needed a dual Republic—with state governments that were almost sovereign, and yet with a central government to give them prestige and power abroad, and cohesiveness at home.

George Washington was one of the first to recognize this necessity and he invited a group of Virginia and Maryland delegates to his home at Mount Vernon in 1785. This was the beginning of informal talks which led, two years later, to the Constitutional Convention in Philadelphia, and ultimately to the second great foundation of our way of life.

The United States Constitution

Twelve of the thirteen colonies sent delegates to the Constitutional Convention. One of them, James Wilson of Pennsylvania, observed: "For the first time in six thousand years of human history, men have come together to deliberate and peacefully resolve what their government shall be."

The delegates were moderate and conservative men. They were truly great men of their times, selected for outstanding intellect, integrity, and love of country.

Their deliberations were not smooth. Great arguments ensued and many stubborn issues were settled in "give and take" compromises.

In its final form, the Constitution was truly the product of centuries. As the great legal anchorage for the American way of life, it provided the base for the political and economic rights of mankind.

Political Rights

Let's build upon this base, therefore, our American political rights. First, the *right to worship God in one's own way.* It is difficult, I know, for the average American to conceive of a people not having religious freedom. And yet it did not exist in the world of 1620, when Plymouth Colony was established on the Atlantic Coast. And in many parts of the world today it does not exist. We Americans must realize how truly priceless is this freedom of worship. It is the greatest of worldly gifts.

Secondly is *the right of free speech*—the freedom to write what we wish in a free press; to say what we wish to say in a public forum or to our neighbor. Why, we can severely criticize the highest officials of our government if we wish. Or, we can disagree with the critics, if we wish. It's a wonderful freedom, isn't it!

There is an exception, however, in the right of free speech. The exception is treason against the United States. Our laws do not protect people who advocate and teach the overthrow of our Government by force and violence. Such people are subject to indictment for violating the provisions of the Smith Act. The trial and conviction of the 11 Communist leaders in New York, for teaching and advocating the violent overthrow of the United States government, stamped Communism in America as a treasonable conspiracy. Our great freedom of speech must not be used to overthrow the government that grants the freedom.

Next is the *right to assemble.* Even the Communists can assemble openly and lambast our form of government—so long as they do not utter their intent, the overthrow by force. Wherever totalitarian governments rule, freedom of assembly does not exist. That means today nearly half the world's people do not have this freedom.

The right to petition for grievances. Isn't it a great privilege that here in America a solitary citizen can challenge his government for grievances? It's done every day. And we have recourse to the courts of the land on any grievance, against anybody.

The right to complete privacy in our own homes. Here again the great principle of private ownership prevails. What is ours is ours, and not even the lofty power of the Federal government can force its way into our home without a search warrant given by the courts for proper causes.

The right of habeas corpus is another great personal right against oppressive government. It prevents our imprisonment beyond a few days unless charges against us have been held justifiable in proceedings in an open court.

The right to trial by jury. Both in the American legal code and in the moral ethics of American life, a man is innocent until he is proved guilty; and he has the right to a trial by jury.

Another great privilege that so many of us Americans take for granted is *the right to move about freely.* Those who have traveled abroad in Europe and Asia know that restrictions and red tape keep you involved constantly with the authorities. The people of countries within the orbit of Communism are afraid to ask for travel permits. In these countries fear lives constantly in the hearts of the people, every hour of the day and night.

And, lastly, among the political freedoms, the right of franchise, *the right to vote freely for the candidates of our choice.* This is more than a right. It is a sacred responsibility of citizenship. If enough Americans neglect it, the right to cast our ballot on election day for whomever we choose will be taken from us. This is a fundamental, a priceless right.

And so we have, in our structure of the American way these political rights. Now let's build on them our economic rights.

Economic Rights

The right of the private citizen to own property is as basically a part of the American way of life as is freedom of worship. If we didn't have this right, we couldn't

have our independence, and thus we would not be free.

And, *the right to work where we choose.* In America we can be an auto mechanic, or a dishwasher, or a lawyer, or an employee in an industrial plant or department—whatever we wish to be. We don't have a commissar or a government bureaucrat assigning us to jobs we may not want—as do the people of Socialist and Communist countries.

The right to bargain collectively with employers. Men and women can come together in unions in America, gaining economic bargaining strength and retaining all the rights that an individual has in relationship to his employers.

The right to go into business risking our capital in an enterprise of production or service. This is the freedom that has made America so materially great.

Coupled with our *right to opportunity,* this freedom to go into business has nourished ambition, enterprise, initiative. It has made America the industrial giant of the world, producing almost as much as all the other nations combined, giving Americans twice as high a living standard as any other people on earth.

The right to seek a profit or sustain a loss, depending upon our ability to manage. Having the freedom to go into business doesn't mean that you automatically succeed. To succeed in the competitive system, you must please your customers and at the same time make a profit.

The right to save is a vitally important right. It has permitted the accumulation of surplus funds which provided the capital for all the growth in America, from the days of Plymouth Colony to the present.

The right to compete; to offer our goods and services in a free market. Competition is the dynamo of the free market. You bake a loaf of bread and sell it for what you can get in competition with other bakers. That's the free market. And in it, the consumer is the boss. If the bread is priced too high, the consumer will bake her own bread at home. This keeps the producers on their toes, makes competition keen, and, in the end, drives prices lower.

The right to contract about our affairs. You can contract to give your services to someone for a cash consideration; or you can contract to purchase the services of someone else. Or you and I can sign a contract committing ourselves to do just about anything we can think of—within the law.

The Government Role

And, over these political and economic rights we have a disciplining force that becomes effective when any of us has an impulse to overstep the legal or moral boundaries of fair play—and some of us occasionally do. We have our structure of disciplining laws and governmental agencies to administer them.

Our Socialist friends say that government ought to become a participant in the economic life of our country, ought to own and operate the major industries. But, most Americans know that wherever this has been tried it has pulled nations down. Most Americans, I'm sure, feel that government's place in our economic system is that of referee, to administer the rules, or laws, in the game of American competition—and not to get into the game as a player. If government gets into the game as a player, it has every advantage over other players, and nobody can call its fouls.

So, these are the elements, the granite blocks in the structure of the American way of life. Here are the principles. Here are the rights and the implicit responsibilities that are fundamental in any structure for genuine human freedom.

American Way of Life

I ask you: Where else in all the world can you find such a combination!

Is this a complex system? Of course it isn't! Is the whole thing an abstraction? Is it confusing? No, it is none of these things.

It is the logical structure for human freedom, logical and simple in its operation. Can we all accept this structure, and thus be on common ground in upholding the simple rights and privileges built into it? I think we can, all of us.

PRESIDENT'S LETTER

The average doctor in Oklahoma has a full and busy life, day in and day out, meeting the demands of his profession in the care of the sick. Add the time which must be spent in keeping up with current medical literature, reasonable family commitments and just a little recreation now and then, and you have a man whose time is pretty well used to the fullest. Knowing this average doctor's schedule, I ask men to serve on various committees of our State Medical Association in a half apologetic manner because I know I am asking for some precious hours. A meeting of the Council or a session of the House of Delegates disrupts a Sunday in many homes, to me the most treasured day in the week, and I promise you that these meetings are not called unless believed to be absolutely vital to our organization.

The meeting of the Council on July 17, a Sunday, was necessary in the main to consider the proposal of the Public Welfare Department regarding payments for medical care of the aged who are eligible for payments from the Department. The meeting was well attended, discussion was lively, and carefully considered decisions were reached, all in spite of clumsy presiding by the chair. It has thus been necessary to call a meeting of the House of Delegates on July 31 for reconsideration of matters discussed at length by the Council and ultimate vote by the Delegates to establish the policy of the Oklahoma State Medical Association. These meetings are long and sometimes tedious but they are vital. I don't particularly like the complexities of the large organization which the Oklahoma State Medical Association has become. The best medical society meeting I have ever attended was in Clinton, Oklahoma, last April for a joint meeting of the Custer-Beckam-Dewey-Roger Mills county medical societies. This meeting was attended by twelve doctors with an attorney, Mr. Shepard of Oklahoma City, as the speaker and leader of the discussion that followed. In a meeting of this size everybody can exchange views freely and the men are reasonably well acquainted with each other. It must be from the nuclei of small societies like this that we get direction in the Council and House of Delegates meetings, because we do get the opinions of pretty clear thinking individuals without too much wrangling. The small county society is essential. The state organization is in turn necessary, and the AMA with its huge operations and hundreds of employees has become an authoritative voice for medicine in this country which we must support.

A physician whose opinions I thoroughly respect gave me great comfort after the last Council meeting when he said, "You know we sometimes go at these problems in curious ways but it seems that eventually we come up with the right answer." I sincerely believe this to be true.

Walter E. Brown, M.D.

Walter E. Brown, M.D.
President

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Because it acts by regulating a basic physiologic imbalance, Aldactone possesses multiple therapeutic advantages in treating edema.

Aldactone inactivates a crucial mechanism producing and maintaining edema — the effect of excessive activity of the potent salt-retaining hormone, aldosterone. This corrective action produces a satisfactory relief of edema even in conditions wholly or partially refractory to other drugs.

Also, Aldactone acts in a different manner and at a different site in the renal tubules than other drugs. This difference in action permits a true synergism with mercurial and thiazide diuretics, supplementing and potentiating their beneficial effects.

Further, Aldactone minimizes the electrolyte upheaval often caused by mercurial and thiazide compounds.

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SUPPLIED: Aldactone is supplied as compression-coated yellow tablets of 100 mg.

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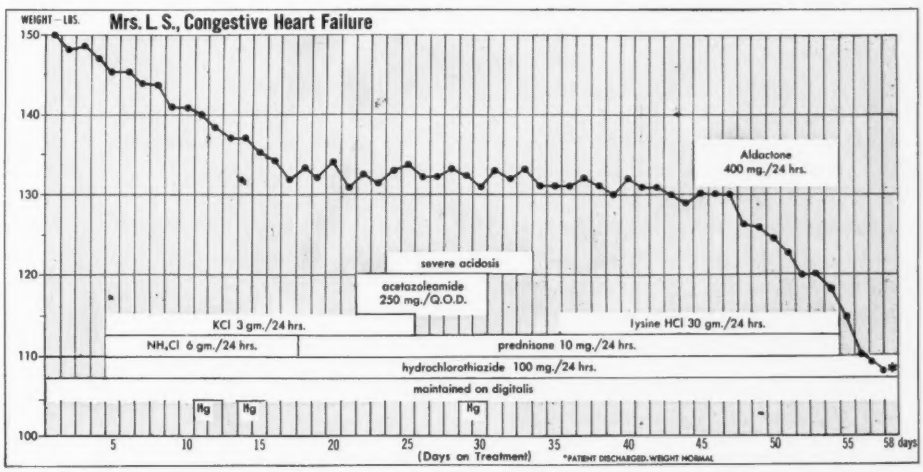


News

President Walter E. Brown, M.D., presides at the Council meeting.

Council Meets In Special Session

Financial distress in the Department of Public Welfare Medical Care Program and two requests from the Oklahoma Osteopathic Association highlighted the proceedings of a special session of the Council of the Oklahoma State Medical Association on July 17.

Problems with Welfare

The physicians heard reports from Alfred T. Baker, M.D., Chairman of the OSMA Committee on Medical Care for Recipients of Public Welfare Assistance, and Mark R. Johnson, M.D., member of the Professional Advisory Committee to the Department of Public Welfare. According to the reports, the medical care program is now in financial straits as a result of a decrease in Federal matching funds which was, in turn, brought on by the transfer of welfare recipients to the Social Security rolls. Despite decreasing funds, the reports said, the cost of the program has largely remained unchanged.

Welfare Recommendations

The reporters, in speaking for their respective groups, recommended that the Oklahoma State Medical Association make certain concessions in its participation in the program, but only until such time as financial balance is restored. A counterpart gesture on the part of the Oklahoma Hospital Association had already received approval from its policy-making body.

In brief, the recommendations to the medical profession envolve the establishment of quarterly maximum fee allowances that a physician may receive for the care of an individual welfare recipient. Medical care identification cards are proposed for the patients, delineating such information as the dates of hospital admissions and the amounts paid out for each.

While the Council declined to take affirmative action on the proposal, it was agreed that the matter should be referred to the House of Delegates (a House of Delegates meeting has been called by President Walter E. Brown, M.D., for July 31).

Osteopaths

The Councilors also heard a report from the Council on Public Policy which pertained to two requests from the Oklahoma Osteopathic Association.

Representatives of the osteopathic association recently asked (1) that the OSMA recognize the propriety of interprofessional consultation between members of the two

Past-President Alfred T. Baker, M.D., left above, is shown presenting a commendatory resolution to Grady F. Mathews, M.D., former Commissioner of Health.

organizations, and (2) that the medical profession endorse the participation of osteopaths in postgraduate courses offered by the University of Oklahoma School of Medicine.

This matter was also referred to the House of Delegates.

Other Actions

In other actions, past-president Alfred T. Baker, M.D., presented a commendatory resolution from the OSMA to Grady F. Mathews, M.D., former Commissioner of Health; continued sponsorship of the Annual Essay Contest of the Association of American Physicians and Surgeons was endorsed; John W. DeVore, M.D., gave a comprehensive report on the 1961 White House Conference on Aging; and, the Council approved Doctor Brown's appointments of Ray M. Wadsworth, M.D., Tulsa, and Carlton E. Smith, M.D., Henryetta, to the professional advisory committees of the crippled children's program and the welfare medical care program, respectively.

Nicholson Re-appointed Editor

Finally, the Council unanimously approved the re-appointment of Ben H. Nicholson, M.D., as Editor of the OSMA Journal, as requested by the president. Doctor Nicholson's resignation had been previously accepted, but he had subsequently volunteered to be reinstated.

Nicholson Honored by Association

Editor Returns to Job

What was intended to be a farewell party for Ben H. Nicholson, M.D., who resigned as Editor of the *Journal* last spring, turned out to be a welcome-back celebration when a group of well-wishers honored the physician at a dinner on June 30. Just a few days before the dinner, Doctor Nicholson informed the O.S.M.A. office that circumstances which prompted him to resign the editorial post had now changed to the extent that he would take his old job back.

When association president Doctor Walter E. Brown learned the news, he not only personally welcomed Doctor Nicholson's return to the position, but also continued with the dinner plans, re-designating the event as an appreciation dinner. During the dinner, Doctor Brown and past-president Doctor A. T. Baker paid tribute to Doctor Nicholson's dedication to the *Journal*.

Doctor Baker presented Doctor Nicholson with a plaque from the Association, inscribed with a message of appreciation for his six years' service to the physicians of Oklahoma.

In response, Doctor Nicholson explained his return to the job and pledged his continued interest in producing a magazine befitting the needs of the profession.

Present for the event were six O.S.M.A. past presidents, members of the Editorial Boards, members of the Executive Committee and representatives from the printing company and the headquarters staff.

'61 Annual Meeting Officials Named

OSMA President Walter E. Brown, M.D., has named two Tulsa physicians to key positions for the planning and conduct of the 55th Annual Meeting of the Oklahoma State Medical Association.

Ceylon S. Lewis, Jr., M.D., Tulsa internist, will serve as General Chairman, and Donald L. Brawner, M.D., Tulsa surgeon, has accepted the position of Program Chairman.

The meeting will be held at Tulsa's Mayo Hotel, May 7, 8, 9, 1961.

AMA Asks Republicans For Conservative 'Aged' Program

The American Medical Association has urged the Republican Committee on Resolutions to adopt, as Party policy, a plan for helping "those of the aged who need help in the financing of their health care."

Doctor Leonard W. Larson, Bismarck, N.D., president-elect of the A.M.A., appeared before the committee that will draft the Republican Party's 1960 platform. He said that "the A.M.A. is entirely in favor of helping those who need help.

"But the association does not believe this necessitates the creation of massive federal machinery to help those who neither need nor want help, and who are capably handling their own problems at the present time."

Doctor Larson pointed out that the majority of the aged are in good health, and that "relatively few of them are hardship cases."

Further, he said, "the effort of private citizens working together at the community level is getting much of the job done already. And private health insurance and prepayment plans now enable most of the aged to finance their own health care under a wide diversity of plans.

"This is as it should be.

"The majority must be allowed to continue its use of the voluntary method without Federal interference. To compel that majority to accept Federal medicine rather than allow it to buy its own medical care voluntarily, through its own resources, subverts the very principles upon which a free, democratic government must be based.

"Those who propose massive Federal intervention in this field are, in effect, denying the right of individuals to pay voluntarily for their own health care and insisting that this right belongs to the Federal Government."

Doctor Larson said that the nation's physicians are "convinced that the health costs of the needy and near needy can best be determined locally, can best be administered locally, and can neither be determined nor administered adequately through mechanisms operating by remote control from Washington, D.C."

He added, "The A.M.A. believes that the Republican Party should base this portion of its health plank on the principle that the Federal Government should help only those who need help, as determined locally; that action should be responsive to the needs of the individual and the community through local administration, and that such action should supplement, rather than supplant, state, local and private action."

The A.M.A. admonition to the Republicans implied an indirect criticism of the action of the Democratic Platform Committee which endorsed the use of the Social Security mechanism to finance health care for the aged.

Doctor McCarley Retires

T. H. McCarley, M.D., has ended forty-six years of practice as a McAlester physician and fifty-three years in the medical profession.

A graduate of the University of Louisville School of Medicine in 1907, Doctor McCarley began his practice in Simmons, Kentucky, moving to Atoka, Oklahoma in 1910 and to McAlester in 1914.

Long active in all phases of the medical profession, Doctor McCarley served as president of the Oklahoma State Medical Association in 1932-33, was a member of the State Board of Health for twelve years and a charter member of the organizing group of Blue Cross.

In addition, he has been active in civic and church affairs in his community. For five years he acted as President of the McAlester School Board and has been a member of the Board of Directors of the Grand Avenue Methodist Church for thirty-five years.

Recognizing his devotion to the medical profession, the Oklahoma State Medical Association has twice-honored Doctor McCarley when they presented him with a Fifty-Year Pin and an Honorary-Life Membership.

Although Doctor McCarley plans to spend more time on his ranch near Cabiness and enjoy much more fishing than usual, he will remain as President of the Medical Arts Corporation in McAlester.

Oklahoma City Clinical Society to Meet in October

Oklahoma City's Biltmore Hotel will once again be the site of the Oklahoma City Clinical Society's Fall Conference. An outstanding program of postgraduate teaching has been arranged for the meeting to be held October 24, 25 and 26.

Fifteen guest speakers who have been secured from various medical and teaching centers throughout the nation are: Robert P. Allen, M.D. (Radiology) Associate Clinical Professor of Radiology, University of Colorado School of Medicine, Denver, Colorado; Stuart W. Arhelger, M.D. (Surgery) Assistant Professor of Surgery, University of Minnesota Medical School, Minneapolis, Minnesota; Don W. Chapman, M.D. (Medicine) Clinical Professor of Medicine, Baylor University College of Medicine, Houston, Texas; Wesley E. Compere, Jr., M.D. (Otolaryngology) Associate Professor of Surgery, (Otorhinolaryngology), University of Southern California School of Medicine, Los Angeles, California; Clifford F. Gastineau, M.D. (Medicine) Associate Professor of Medicine, University of Minnesota Graduate School, Rochester, Minnesota; Louis J. Girard, M.D. (Ophthalmology) Professor and Head, Division of Ophthalmology, Baylor University College of Medicine, Houston, Texas; Charles F. Gregory, M.D. (Orthopedic) Associate Professor of Surgery, Chairman Division of Orthopedic Surgery, University of Texas Southwestern Medical School, Dallas, Texas; Stanley F. Hampton, M.D. (Allergy) Assistant Professor of Clinical Medicine and Director of Allergy Clinic, Washington University School of Medicine, St. Louis, Missouri; Howard C. Hopps, M.D. (Pathology) Professor and Chairman, Department of Pathology, University of Texas-Medical Branch, Galveston, Texas; Howard W. Jones, Jr., M.D. (Gynecology) Associate Professor Gynecology, Johns Hopkins University School of Medicine, Baltimore, Maryland; Edward T. Krementz, M.D. (Surgery) Associate Professor of Surgery, Cancer Teaching Coordinator, Tulane University School of Medicine, New Orleans, Louisiana; Walter C. Lobitz, Jr., M.D. (Dermatology) Professor and Head, Division of Dermatology, University of Oregon Medical School, Portland, Oregon; Theo. C. Panos, M.D. (Pediatrics) Professor and Chairman, Department of Pediatrics, University of Arkansas Medical Center, Little Rock, Arkansas; E. H. Parsons, M.D. (Psychiatry) Assistant Clinical Professor of Neuropsychiatry, Washington University School of Medicine, St. Louis, Missouri; Robert A. Ross, M.D. (Obstetrics) Professor and Chairman, Department of Obstetrics and Gynecology, University of North Carolina School of Medicine, Chapel Hill, North Carolina; and Doctor John H. Furbay, Internationally Known Lecturer and Director of Global Education Program of T.W.A., New York City, New York.

In addition to the general assemblies, there will be specialty lectures, a clinical pathologic conference, and daily roundtable luncheons with question and answer sessions.

Entertainment will include a banquet on Monday evening at which time the Oklahoma County Medical Society will be host to the guest lecturers and out-of-town doctors. Doctor John H. Furbay, lecturer and director of global education program of Trans World Airlines, will be principal speaker of the evening. On Tuesday evening, there will be a social hour followed by eight specialty group dinners. Climaxing the three-day conference, the annual dinner-dance sponsored by the Oklahoma City Chamber of Commerce and the Oklahoma City Clinical Society will be held.

The Clinical Conference is acceptable for twelve hours of Category I Credit by the American Academy of General Practice. Registration fee of $20.00 includes all features.

After June 15, 1960, physical examinations for FAA Class I, II, and III medical certificates must be conducted by a physician designated as an FAA medical examiner by the Federal Aviation Agency.

Doctor Mosley Appointed Commissioner of Health

"A public health worker has to be something of a missionary," employees of the State Health Department mused, and Doctor Kirk T. Mosley, newly appointed State Commissioner of Health is just that. While serving as a medical missionary in China, Doctor Mosley practiced at Tsing-Kiang-pu General Hospital, a mission hospital with an average of 5,000 in-patients and 70,000 out-patients per year. Two years were also spent as Superintendent of the Yencheng Christian Hospital. During this time Doctor Mosley become more and more interested in public health. "I saw people dying in the streets from cholera while the vaccine was available to prevent it, but superstition kept them away," the doctor recalled thoughtfully. "It was then I recognized the importance of prevention, and the need for individuals to be informed about what services exist and how to go about taking advantage of these benefits."

Arkansas is Doctor Mosley's home state, and he graduated from Hendrix College at Conway, Arkansas before entering Tulane University for his medical degree. After his return from China, the young doctor took a position as interne and later resident of City Hospital, Little Rock to become familiar with the medical advances made during his absence from the United States.

Once again Doctor Mosley returned to school—this time to Harvard where he received his M.P.H. and his Dr.P.H. degrees.

His early experience in public health was with the Arkansas State Health Department where he was medical director of two county health units. Later as medical officer in the U.S. Army, Doctor Mosley was assigned to the Preventive Medicine Section of the Surgeon General's Office and then to the Office of the Surgeon of the China-Burma-India Theater as Theater Epidemiologist.

In addition to his career as a physician and public health administrator, Doctor Mosley has had much teaching experience. Students at Tulane University, Vanderbilt University, and the University of Oklahoma remember him as a dynamic teacher of epidemiology. At the O.U. Medical School he was professor of Preventive Medicine and Public Health and chairman of that department.

At the time of his appointment as commissioner, Doctor Mosley was an associate dean of the University of Oklahoma School of Medicine.

Early each morning Doctor Mosley is vigorously at work in his large corner office located in "the big white building" at 3400 North Eastern in Oklahoma City. One coworker commented, "Doctor Mosley's enthusiasm for his work and his belief in publice health will spur us all to greater efforts in our chosen profession." His interest in public health can be observed beyond office hours in his work with the Oklahoma Health and Welfare Association, the Oklahoma State Heart Association, and the Conference of State Directors of Public Health Training.

Two M.D.'s Added To Committees

OSMA President Walter E. Brown, M.D., has announced the appointments of Homer A. Ruprecht, M.D., Tulsa, and B. C. Chatham, M.D., Chickasha, to positions on the Professional Liability Committee and the Prepaid Medical Care Committee, respectively.

It's in the Bag!

Watch your bag! Safeguard it at all times! Of late there has been an alarming increase in the number of thefts of doctors' bags and drug store burglaries. More effective enforcement of the narcotic laws has resulted in removal from the streets of the pushers and peddlers, and addicts are being forced to drug store burglaries and theft of doctors' bags to obtain a supply of narcotics. Don't leave your bag in your car unless absolutely unavoidable. Leave it protected in your office or home. Should you have to leave it in your car, be sure your car is securely locked and the bag out of sight. Carry in your bag only those narcotic drugs that are absolutely essential. If thieves obtain little or no narcotic drugs from the theft of these bags, it will soon discourage them.

American Heart Association to Hold Scientific Sessions

The American Heart Association's 33rd annual Scientific Sessions, to be held at Kiel Auditorium, St. Louis, from Friday, October 21 through Sunday, October 23, will present six sessions of broad clinical interest to run concurrently with the investigative scientific programs. Also included are programs of particular interest to dentists and nurses.

The six clinical programs, stressing the application of findings in cardiovascular research, will be proportioned among symposia, panels, lectures of general interest and submitted papers on recent results of research. As in the past, these sessions have been classified by the American Academy of General Practice as acceptable for Category II credit for Academy members.

The opening scientific session on Friday, October 21, will include introductory remarks by A. Carlton Ernstent, M.D., President of the American Heart Association; the Lewis A. Conner Memorial Lecture on Physiology of the Circulation as Viewed by the Internist," by Eugene A. Stead, Jr., M.D., Professor and Chairman of Medicine, Duke University School of Medicine. The remainder of the session will be conducted jointly by the AHA Council on Clinical Cardiology and the American College of Cardiology.

"Fireside Conferences" sponsored jointly with the American College of Cardiology are scheduled for Friday evening.

Saturday's program includes presentation of the Association's Albert Lasker Award and the George E. Brown Memorial Lecture on "Clinical Physiology of the Splanchnic Circulation," by Stanley E. Bradley, M.D., Professor of Medicine, and Chairman of the Department, Columbia University College of Physicians and Surgeons.

Included in Sunday's sessions are three symposia on the subjects of "Complete Heart Block," "Nondietary Factors in Coronary Artery Disease," and "Lipids and Arteriosclerosis." Following a similar program presented successfully last year, Sunday's sessions will also include morning and afternoon showings of cardiovascular films, each of which will be introduced and discussed by the author or other authority on the subject.

This year for the first time a session for dentists has been scheduled to be held on Friday afternoon. Also, following its enthusiastic acceptance in 1959, a program for nurses has been scheduled for Saturday morning and afternoon.

As in previous years, scientific and industrial exhibits will be on display in the Auditorium.

Forms for registering and for reserving accommodations may now be obtained from the American Heart Association, 44 East 23rd Street, New York 10, N.Y.

State Heart Association Names New Officers

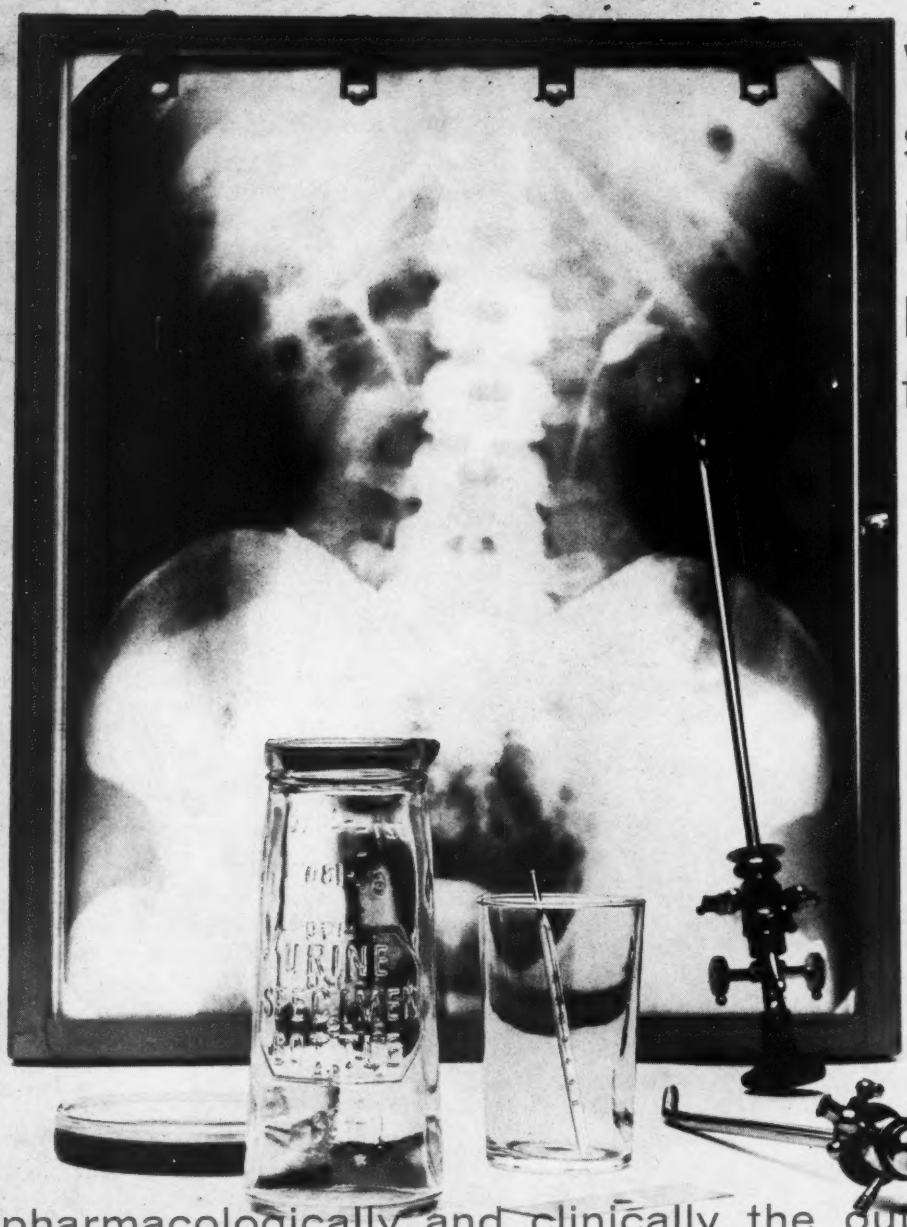
E. C. Mohler, M.D., Ponca City became a Vice-President of the Oklahoma State Heart Association at the organization's recent Annual Meeting. He will serve with Joseph G. Rucks of Oklahoma City, newly elected president and C. S. Lews, Jr., M.D., Tulsa, immediate past president and now Chairman of the Association's State Executive Committee.

Four Oklahoma physicians were elected to the Association's Board of Directors for three year terms. They are: LeRoy Engles, M.D., Durant; Leon C. Freed, M.D., Stillwater; Harold H. Jones, Jr., M.D., Ponca City; and Stewart G. Wolf, M.D., Oklahoma City.

Other new board members include: Ted L. Kimbro, Idabel; Miss Julia Marlow, Pawnee; John Morgan, Oklahoma City; Miss Grace L. Spivey, Stillwater; Mrs. J. Dudley Wilkinson, Shawnee; and Mr. Leo Hicks, Duncan.

Both Doctor Mohler and Doctor Lewis were re-elected for three-year terms of office on the Board of Directors.

Other re-elected board members were: Robert H. Bayley, M.D., and Wm. Best Thompson, M.D., both of Oklahoma City; Hugh O. Davis, Shawnee; and L. D. Lacy, Oklahoma City.



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Successful against these organisms: streptococci, staphylococci, E. coli, A. aerogenes, paracolon bacillus, Gram-negative rods, pneumococci, diphtheroids, Gram-positive cocci and others. •

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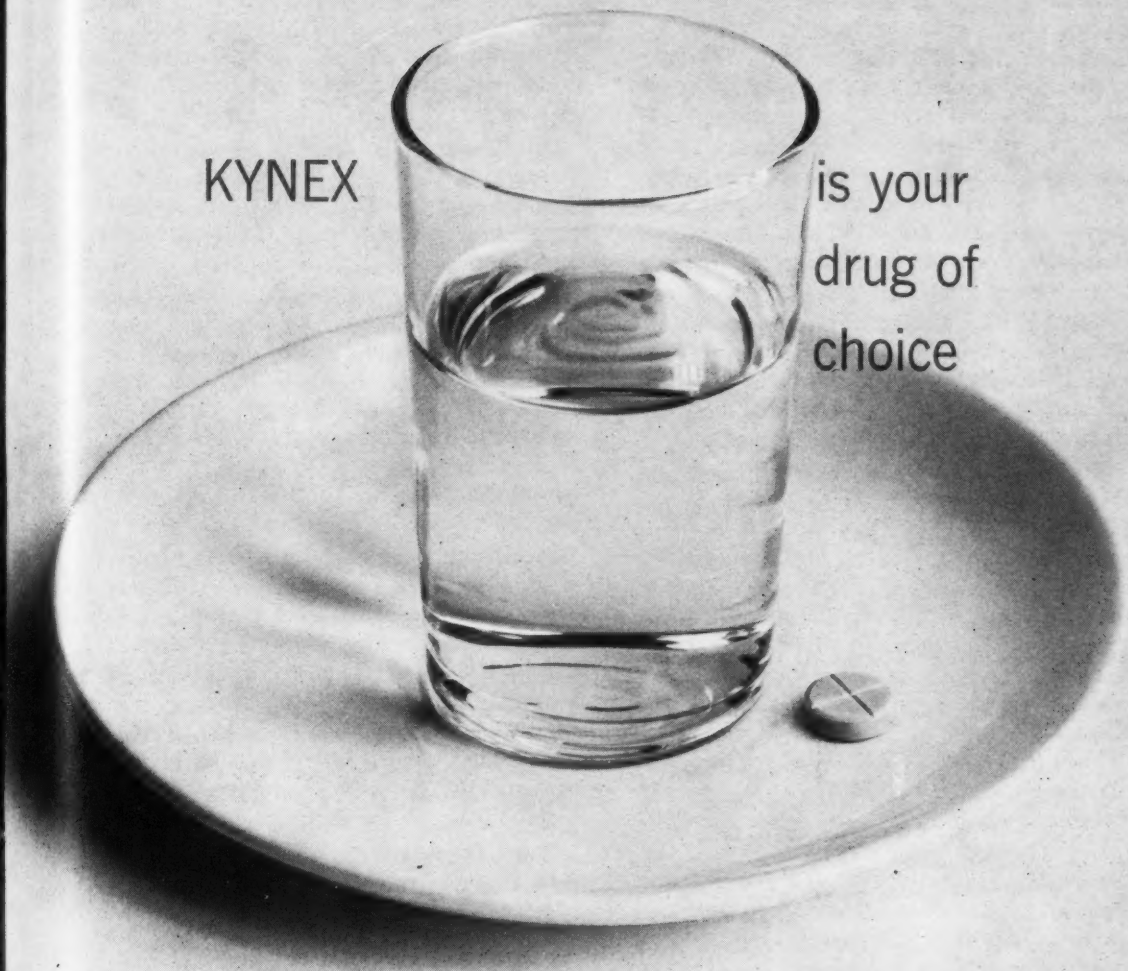

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KYNEX Tablets, 0.5 Gm., bottles of 24 and 100. Dosage: Adults, 0.5 Gm. (1 tablet) daily, following an initial first day dose of 1 Gm. (2 tablets).

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OU Alumni Launches Ten Year Improvement Program For Medical Center

Executive Secretary Employed

Projected goals and activities of the Alumni Association of the University of Oklahoma School of Medicine for aiding in the development of a Medical Center for Oklahoma that will meet the state's present and long-range needs have so progressed that an executive secretary has been employed, it was announced recently by Alumni President John R. Taylor, M.D., Kingfisher, Okla.

The Alumni Association has employed Lawrence W. Rember, 425 N.W. 44th Street, Oklahoma City, for the newly-created position.

For the past 12 years, Hugh Payne, Executive Vice President of the Oklahoma Medical Research Foundation, Oklahoma City, has served as volunteer executive secretary. He will continue as volunteer consultant.

Progressive forward steps outlined for the Medical Center and School of Medicine, located at 800-815 N.E. 13th Street in Oklahoma City, call for enlistment of lay leaders and organizations, the general public, the legislature, university and higher education regents, government officials, and the medical profession in achieving first-class medical health facilities for Oklahoma. A 10-year projected program is being designed to meet the medical center needs of all ages, the aged, those in middle life, the young, children, and infants.

Initially a thorough study will be made of the various units comprising the present Medical Center, School of Medicine, and teaching hospitals to secure firsthand facts and figures as a prelude to preparing a plan of action for building, equipping, staffing, financing, and maintaining a front rank medical health center in serving the people of Oklahoma.

Mr. Rember brings considerable medical and health experience to his new position. He served as nationwide Field Secretary of the American Medical Association for three years and as Director of Public relations and Executive Assistant to the General Manager for four years. He was Director of Public Relations for the American Hospital Association's Blue Cross Plans Commission for the United States and Canada for two years. He directed public information for the American Red Cross for the 17-state Midwestern Area, including Oklahoma, for two years.

He has held executive director, public relations director, and editorial positions with other national professional and trade associations.

Mr. Rember was graduated this May at the age of 52 with the degree of Bachelor of Laws obtained by four years of nighttime study at Oklahoma City University. During the past three years by daytime study at the College of Law at the University of Oklahoma, he has taken 25 semester hours in law beyond LL.B. degree requirements. He holds also an M.S. degree from Northwestern University and an A.B. degree from the University of Wisconsin in Journalism-Commerce. He taught journalism and advertising for one school year at the University of Georgia.

He is a member of Sigma Delta Chi honorary journalism fraternity, a charter member of the National Association Executives Club of Washington, D.C., the Public Relations Society of America, and Delta Phi, honorary legal fraternity. He is a Sigma Chi, and attends the Methodist Church. Mr. Rember's wife Muriel served formerly as executive secretary of the Oklahoma County Medical Society for eleven years.

Members of the Executive Committee of the Alumni Association with whom Mr. Rember will work most closely are: President John R. Taylor, M.D., President-Elect Wilbur Lewis, M.D., Lawton, Past-President Wendell Smith, M.D., Tulsa, Secretary Samuel T. Moore, M.D., Oklahoma City, and Treasurer Wayne A. Starkey, M.D., Altus. Dean Mark Everett, Director of the Medical Center and Dean of the School of Medicine, is an ex-officio member.

In the near future, the 37 trustees of the Alumni Association, located throughout Oklahoma, will be visited by Mr. Rember for the purpose of obtaining their help and counsel to assist in developing a most modern and complete Medical Center for Oklahoma. Regular members of the Alumni Association include O. U. medical school grad-

uates practicing in Oklahoma and elsewhere in the United States. Life members and associate members include both O. U. and non-O. U. medical school graduates. Of the 2,200 O. U. medical school alumni, about 1,800 are presently in active medical practice.

Other main goals of the Alumni Association besides: 1) fostering the growth of the Medical Center by developing and following a 10-year plan, are 2) encourage adequate medical postgraduate studies, 3) develop the Alumni Association into a more closely knit medical health functioning unit, 4) establish beneficial liaison with students in the School of Medicine, and 5) the Alumni Association, having initiated and provided continuing influence in the development of the Oklahoma Medical Research Foundation, intends to continue such support in any further advances.

Attorney General Rules Against Incorporation

Physicians may not practice medicine and surgery as a corporation, according to a July 6 opinion of the Attorney General of Oklahoma.

Prior to this development, it was believed to be authorized by many Oklahoma lawyers, under 59 O.S. 1951, paragraph 510. Ethical barriers against practice as a corporation were removed by the AMA in 1957 when the House of Delegates approved a resolution which permitted such organization (if legal under state laws) provided the physicians own and manage the corporation and continue to be individually responsible for their ethical conduct.

The provision of paragraph 510, the opinion stated, specified what to do after incorporation was affected, but did not, in fact, establish general law authorizing such incorporation. The opinion further reasoned that the 1923 Legislature approved the Medical Practice Act (par. 510 was a provision therein) without realizing that such corporations were not provided for under existing corporate laws. It was therefore ruled that the reference to the creation of a corporation in the Medical Practice Act was voided because it was beyond the scope of the title of the act.

Have You Heard?

ROBERT LEMBKE, M.D., formerly of Pryor, has accepted the position of chief of the occupational medical department, of the Ponca City division, Continental Oil Company.

Taking Doctor Lembke's place in Pryor will be Sherman A. Hope, M.D., a 1957 graduate of the University of Oklahoma School of Medicine.

W. PAUL DICKINSON, M.D., former Tecumseh physician, has joined the staff of the Broadway Clinic in Shawnee. Doctor Dickinson graduated from the University of Oklahoma School of Medicine and completed his residency in obstetrics and gynecology at Vanderbilt University Hospital in Nashville.

WILLIAM O. ELLIFRIT, M.D., a 1959 graduate of the University of Oklahoma School of Medicine, recently moved to Seminole where he will be a staff member of the Harrison-Parrish Clinic in general practice.

PHILLIP H. MCCLURE, a '60 graduate of Amherst College and son of H. M. McClure, M.D., past president of the Oklahoma State Medical Association, was recipient of the Woods-Travis Prize, an award for outstanding improvement in his class "as a man and a scholar."

After seven years of general practice in Nowata, JAMES H. ELLIOTT, M.D., a 1952 graduate of the University of Oklahoma School of Medicine, has begun a two-year residency in ophthalmology at the University of Oklahoma Medical Center.

SAMUEL E. DAKIL, M.D., a graduate of the University of Oklahoma School of Medicine, has joined the staff of the McAlester Clinic. Doctor Dakil's specialty is E.N.T.

ROBERT G. BISSELL, M.D., formerly of Sioux Falls, South Dakota, is now associated with George R. Booth, M.D., in the Booth Clinic in Wilburton. Doctor Bissell is a graduate of the University of Oklahoma School of Medicine.

Coming Meetings

CORONARY ARTERY DISEASE

Nov. 28-Dec. 2, 1960 — **Texas Medical Center, Houston, Texas**

The University of Texas Postgraduate School of Medicine will present a symposium on Coronary Artery Disease, November 28 through December 2, 1960 at the Texas Medical Center, Houston, Texas. Six guest lecturers, augmented by a local faculty, will present the program.

This five-day program has been approved by the Academy of General Practice for Category I Credit. No tuition will be charged unless physicians attending desire AAGP credit in which case a $5.00 registration fee will be required.

For further information write: Office of the Dean, University of Texas Postgraduate School of Medicine, 410 Jesse Jones Library Building, Texas Medical Center, Houston 25, Texas.

9th WESTERN CARDIAC CONFERENCE

August 15-20, 1960 — **Denver, Colorado**

The 9th Western Cardiac Conference will be held in Denver, Colorado, August 15-20, 1960. Ten out-of-state speakers have accepted invitations to speak for the three-day session. Meetings will be held in Phipps Auditorium. Further information may be obtained from Colorado Heart Association, 1636 Logan Street, Denver 3, Colorado.

POSTGRADUATE COURSE IN PEDIATRICS

The University of Colorado School of Medicine

September 1-6, 1960 — **The Stanley Hotel, Estes Park, Colorado**

The Department of Pediatrics and the Office of Postgraduate Medical Education, University of Colorado School of Medicine will present a Course in Pediatrics at the Stanley Hotel, Estes Park, Colorado, September 1-6, 1960.

Sixth Annual Meeting
AMERICAN RHINOLOGIC SOCIETY

October 8, 1960 — **Chicago, Illinois, Belmont Hotel**

The American Rhinologic Society will hold its sixth annual meeting at the Belmont Hotel, Chicago, October 8, 1960.

No registration fee will be required and further information may be obtained by writing Robert M. Hansen, M.D., secretary, American Rhinologic Society, 1735 North Wheeler Avenue, Portland 17, Oregon.

COURSE IN LARYNGOLOGY AND BRONCHOESOPHAGOLOGY

October 17-20, 1960 — **University of Illinois College of Medicine, Chicago, Illinois**

The Department of Otolaryngology, University of Illinois College of Medicine, will conduct a postgraduate course in Laryngology and Broncheosophagology from October 17 through October 29, 1960, under the direction of Paul H. Holinger, M.D.

Registration will be limited to fifteen physicians who will receive instruction by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants may write to the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

FOURTH NATIONAL CANCER CONFERENCE

September 13-15, 1960 — **Minneapolis, Minnesota**

The Fourth National Cancer Conference will be held September 13-15, 1960 in Minneapolis, Minnesota. Further information may be obtained by writing to Roald N. Grant, M.D., Coordinator, American Cancer Society, Inc., Medical Affairs Department, 521 West 57th Street, New York 19, New York.

SOUTHERN TRUDEAU SOCIETY
and
SOUTHERN TUBERCULOSIS CONFERENCE

September 14, 15, 16, 1960 — **Hotel Francis Marion, Charleston, South Carolina**

The 1960 Annual Meeting of the Southern Trudeau Society and the Southern Tuberculosis Conference will be held on September 14, 15, and 16, 1960 at the Hotel Francis Marion, in Charleston, South Carolina. Information may be obtained from Judson M. Allred, Jr., Secretary-Treasurer, Southern Tuberculosis Conference, P.O. Box 9865, Northside Station, Jackson, Mississippi.

6th INTERNATIONAL CONGRESS OF INTERNAL MEDICINE

August 24-27, 1960 — **Basle, Switzerland**

The 6th International Congress of Internal Medicine will convene in Basle, Switzerland, August 24-27, 1960. Simultaneous translation for the principal speakers will be given in German, French and English. Programs and registration forms are available from the 6th International Congress of Internal Medicine, Steinentorstrasse 13, Basle 10, Switzerland.

Auxiliary News

Mid-Summer Slump

By the middle of August most Auxiliary members are adjusted to the hard fact of living: tranquility is somewhat illusory, a summer idyll concocted during busier winter months. Our own organizational activities seem dormant—but only on the surface.

Legislation + Public Relations

Legislation and Public Relations are two year-around fields, and are infinitely interrelated. Granted, there have been no emergency contacts recently; but as both political parties swing into high gear before the November election, our awareness of platforms and issues should become intensified. Often, too often, we are accused of being politically-minded as a group only when medical issues are pending.

Do you feel this accusation is a just and fair one for you and for your Auxiliary? If you do, then what better time is there to start reading, studying and discussing broader political issues? Your "educated" outlook can improve your Public Relations at the same time. Much depends upon the manner in which it is done. (Those people who blandly lock the door with the statement: "I never discuss politics with my friends," have no idea of what they are missing with their friends in the realm of understanding.)

Points From National

During the convention in June, printed suggestions on legislation were presented to the convention in a booklet: *The Road to Effective Citizenship.* After summarizing the meaning of good government, a citizen's responsibilities, and "some political facts of life," our National Committee on Legislation submitted the following steps necessary toward securing the best government possible:

1. Take an active, willing, and interested part in the affairs of the community. This means real participation in PTA groups, young people's activities, fund drives, church work, and so on.

2. Plan your contributions of time in such community activities in the same manner that you plan your budget or your tithe. Concentrate on making *real* contributions, but don't scatter your shots.

3. Participate actively in the local political party of your choice. Let the party organization know you are willing to work. Help with political rallies, dinners and meetings; all are affairs essential to party morale. Help with fund-raising is obviously important. "If you are active and hard-working, you will have a say in the end result. If you are not and do not like the results, *not a soul will note your tears!*"

4. Take a stand if you believe in a cause or a candidate. Many of the friends you make in your community will be grateful for guidance. (As noted before, your convictions must be based on your own knowledge and insight, based on thorough study.)

5. Write to your congressmen and urge your friends to do the same. When your congressman takes a position you have recommended, write and thank him.

6. Remind your doctor husband that his most devoted and grateful friends are his satisfied patients. Urge them to help out in political issues of the day. They will welcome a chance to do something. (Our Legislative Committee mentions that the doctors of America see two million patients a day.)

7. Get into politics and have some fun. You will find nothing else quite so exhilarating.

8. Be proud of your part in politics as perhaps your highest form of social endeavor.

With all of these suggestions certainly no County Legislation Chairman can feel that mid-summer slump can in any way effect her particular field. Convinced?—then study and start convincing others right away. Our State Legislation and Key Woman is Mrs. Joseph W. Kelso, 319 N.W. 18th, Oklahoma City.

The basic question is whether we are to discard the system that has brought us to our present level of health care, and promises much higher levels for the future, in favor of a regulatory strait jacket that stifles initiative, bureaucratizes research, and promises nothing for the future.

You can't go places in a strait jacket...!

An editorial writer recently made the interesting suggestion that the pharmaceutical industry might have avoided much of the current public interest in its affairs if they had simply restricted themselves to making aspirin tablets and rubbing alcohol, competing only by debating which aspirin dissolves faster. • No one has seriously suggested a return to the "good old days" in therapeutics, but there are apparently some who would like to destroy the system that has produced for us the finest medical care in the history of the world. Whether they attack the freedom of the patient to choose his physician, the freedom of the physician in the practice of his profession, or the freedom of the pharmaceutical industry is immaterial. • If the desideratum is simply maintenance of the status quo in health care, medicine might well have rested on its 19th century laurels and the pharmaceutical industry on aspirin tablets and rubbing alcohol.

This message is brought to you on behalf of the producers of prescription drugs as a service to the medical profession. For additional information, please write Pharmaceutical Manufacturers Association, 1411 K Street, N.W., Washington 5, D. C.

Deaths

Charles Ed White, M.D.
1893-1960

Charles Ed White, M.D., died July 7, 1960 in Muskogee.

Born in 1893, Doctor White graduated from the University of Tennessee Medical School in 1923, later specializing in obstetrics and gynecology. Following many years of private practice in Muskogee, he assumed duties as staff physician at the State War Veterans Home in Sulphur, Oklahoma in 1957.

Doctor White was a member of the Oklahoma State Board of Health.

In 1957, he was honored for his years of service to the medical profession when the Oklahoma State Medical Association presented him with a Life Membership.

John Fish Park, M.D.
1887-1960

John Fish Park, M.D., 73-year-old McAlester physician, died July 6, 1960.

Born in New Brighton, Pennsylvania in 1887, Doctor Park graduated from Jefferson Medical College, Philadelphia in 1914. He was a member of the American College of Surgeons, the American Board of Surgery and a Fellow of the Academy of International Medicine.

Doctor Park served for four years on the State Board for Crippled Children's Society.

In 1958, Doctor Park was made an Honorary-Life Member of the Oklahoma State Medical Association in recognition of his years of service to the medical profession.

John Stanley Callahan, M.D.
1897-1960

John Stanley Callahan, M.D., long-time Wilburton physician, died at his home July 9, 1960.

Born in Salem, Missouri, in 1897, Doctor Callahan graduated from the University of Oklahoma School of Medicine in 1924.

Doctor Callahan practiced medicine in Heavener, Oklahoma from 1926 to 1933 before moving to Wilburton.

Albert C. Bailey, M.D.
1870-1960

Albert C. Bailey, M.D., 89-year-old, retired Holdenville physician, died June 27, 1960 in Holdenville.

Born in Malvern, Arkansas in 1870, Doctor Bailey attended Arkansas University Medical School. He practiced medicine in the Indian Territory and later in Lone Oak, Arkansas before coming to Holdenville.

Doctor Bailey served as deputy county clerk for Hughes County for thirteen years and as county clerk for four years. He retired from active practice in 1940.

PHYSICIAN PLACEMENT

General Practice

Johnny Bill Delashaw, U.S.P.H.S. Hospital, Wyman Park Drive and 31st Street, Baltimore 11, Maryland, age 27, married, University of Texas Medical Branch, 1959, available July 1960.

John William Kennard, M.D., Blowing Rock Hospital, Blowing Rock, North Carolina; married; age 29; Bowman Gray School of Medicine, 1956; veteran; available August 29, 1960.

Carle H. Schroff, M.D., 3811 State Line, Kansas City 11, Missouri: Age 31; married; University of Kansas, 1959; veteran; available August, 1960.

Internal Medicine

Thomas Turner Walton, Jr., M.D., 7375 Churchill, Detroit, Michigan: Age 29; married; Baylor College of Medicine, 1955; Board eligible; veteran; specialty, internal medicine; desires group or associate practice; eligible, July 1961.

Locum Tenens

Harold W. Calhoon, M.D., Wesley Hospital, Oklahoma City. One year residency in Internal Medicine. Available July 1 to September 15th, 1960.

Arnold Giesbrecht, M.D., Hallock, Minnesota, age 34, married, graduate Winnipeg, Manitoba, 1957, prefers suburban or locality close to cities.

Russell M. Preston, M.D., 476 San Juan, Oak Harbor, Washington, desires six month's work in General Practice between time of separation from military service to beginning of residency training, January-July, 1960.

Obstetrics and Gynecology

Gerald R. Keilson, M.D., Medical Arts Building, Dallas, Texas, age 31, married, University of Texas, 1953, board qualified, veteran, available in July 1960.

Juan C. Ruiz, M.D., 350 Park Ave., Lexington, Kentucky; age 36; married; University of San Marcos Medical School 1952; no military obligations; available July 1, 1960.

Robert B. Williams, M.D., 27 Normandy Road, Auburndale 66, Massachusetts; married; age 30; Tulane University, 1955; board certified; available July 1, 1961.

Orthopedics

Newsom Stool, M.D., c/o Mayo Clinic, Rochester, Minnesota; age 30; married; Baylor University 1953; Board eligible; available July 1960.

Urology

Alex Grossman, M.D., V.A. Center, Temple, Texas, 42, married, University of Texas, 1951, board certified, veteran, available now.

Surgery

Clarence I. Britt, M.D., 1650 Neil Avenue, Apt 15, Columbus, Ohio; age 32; married; Ohio University College of Medicine, 1951; American Board of Surgery 1959; eligible American Board of Thoracic Surgery, 1960; inactive reserve; available July 1960.

Attend The

Oklahoma City
Clinical Society
FALL CONFERENCE

Biltmore Hotel • Oklahoma City • October 24, 25, 26